Department of Health Care Policy and Financing
Line Item Description
FY 2015-16 Budget Request

November 1, 2014

I. LINE ITEM DESCRIPTION

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office Long Bill group of the Department's budget contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determination, client and provider services, utilization and quality review, and information technology contacts. This division is divided into eight subdivisions.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, personal services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department. A description of each line item is presented below.

PERSONAL SERVICES
This line item funds the majority of the Department's expenditures for FTE, temporary staff, and some of its contractors. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through this line item. It excludes expenditures for those FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities.

HEALTH, LIFE, AND DENTAL
This line item funds the Department's health, life, and dental insurance benefits, and is part of the POTS component paid jointly by the State and state employees. The calculated annual appropriation is based upon recommendations contained in the annual Total Compensation Report, and associated guidance from OSPB, and is calculated based upon employee benefits enrollment selections.

SHORT-TERM DISABILITY
This line item, a component of POTS, provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. This benefit is calculated on an annual basis in accordance with OSPB Common Policy instructions.

AMORTIZATION EQUALIZATION DISBURSEMENT

This line item funds the increased employer contribution to the Public Employees' Retirement Association **(**PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY

The Salary Survey appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the Total Compensation survey performed annually by the Department of Personnel and Administration. The annual request for this line item is calculated based upon the annual Total Compensation recommendations from the State Personnel Director, along with guidance provided via the OSPB Common Policy Instructions.

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. It is similar to the Amortization Equalization Disbursement discussed above, however, this line is funded through a reduction of the proposed Salary Survey increases for the upcoming fiscal year. This amount is ultimately paid through the Personal Services line item, through a defined percentage of the employee's salary. The request for this line item is computed in accordance with OSPB Common Policy Instructions, and is calculated using the sum of base salaries, Salary Survey, and Merit Pay adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235, which created this line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

MERIT PAY

Formerly known as "Performance Achievement Pay," Merit Pay represents the annual amount appropriated for periodic salary increases for State employees based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work.

WORKERS' COMPENSATION

This line item provides funding for payments made to the Department of Personnel and Administration (DPA) to support the State's self-insured Worker's Compensation program. Workers' Compensation is a statewide allocation to each Department based upon historic

usage. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and Common Policy adjustments. DPA's actuaries determine departmental allocations.

OPERATING EXPENSES
In addition to funding telephones, computers, office furniture, and employee supplies associated with the Department's staff, this line also supports a number of annual costs such as in- and out-of-state travel, building maintenance and repairs, storage of records, telephones and postage, costs for the Department's call center, and subscriptions to federal publications.

LEGAL SERVICES
This Common Policy line item funds the Department's expenditures for legal services provided by the Department of Law. The Department is billed based on a blended attorney/paralegal hourly rate developed by the Department of Law.

ADMINISTRATIVE LAW JUDGE SERVICES
This Common Policy line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. Departmental appropriations are based upon historical utilization of these services, by applying the prior year's billable hours to the estimated billable cost for the request year. Adjustments are made based on mid-year reviews by the Department of Personnel and Administration.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS
This Common Policy line item is an allocation appropriated to each department based on a shared statewide risk formula for property and liability insurance coverage, also known as the Liability Program and Property Program. Prior to FY 2007-08, the Department did not participate in the Property Program. However, for FY 2007-08, the Department of Personnel and Administration adjusted its policy and began billing the Department for the Property Program portion.

LEASED SPACE
Previously called Commercial Leased Space, this line item was established in FY 2003-04 as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258). The line item is necessary to pay for the Department's obligations for leases of private office space and other facilities that are not State-owned.

CAPITOL COMPLEX LEASED SPACE

This Common Policy line item is appropriated to cover program costs and overhead associated with the maintenance and property management functions provided by the Division of Central Services, Facilities Maintenance for the 31,512 square feet of space the Department occupies at 1570 Grant Street.

PAYMENTS TO OIT

Starting in FY 2014-15, this Common Policy line item combines four OIT-related line items that were previously separated in the Long Bill. These lines included the following:

- Purchase of Services from Computer Center, which funded the Department's use of centralized computer services;
- Colorado State Network, which funded the Department's share of costs associated with the provision and administration of the Colorado State Network;
- Information Technology Security, which funded the implementation of Secure Colorado, a three-year initiative to begin to mitigate current information security risks; and,
- Management and Administration of OIT, which funded the Department's share of OIT's internal office expenses.

COFRS MODERNIZATION

Common Policy line item resulted from the passage of HB 12-1335, the FY 2012-13 Long Appropriations Bill. It funds the first two phases of a five-phase project to replace the statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures. The new system is needed to meet the State's fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality. The new system will be built in the cloud environment by a private vendor in collaboration with state personnel. The five-phase project incorporates all of the components necessary to replace COFRS.

SCHOLARSHIPS FOR RESEARCH USING THE ALL-PAYER CLAIMS DATABASE

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to fund scholarships for nonprofit and government entities to access and conduct research in the All-Payer Claims Database. The Database was created in 2010 and combines claims data from commercial health plans, Medicare, and Medicaid. It is administered by the Center for Improving Value in Health Care.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in 2008 and is appropriated funding for special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO OTHER DEPARTMENTS

TRANSFER TO DPHE FOR FACILITY SURVEY AND CERTIFICATION

The Department of Public Health and Environment (DPHE) is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. Federal regulations at 42 C.F.R. § 488 authorizes and sets requirements for both Medicare and Medicaid surveys and certification of health facilities. This line item helps to fund the survey and certification of nursing facilities, hospices, home health agencies, and Home- and Community-Based Services agencies (including alternative care facilities, personal care/homemaking agencies, and adult day services) by paying the Medicaid share. The Department also pays DPHE to maintain and operate the Minimum Data Set resident assessment instrument, which is used for nursing facility case mix reimbursement methodology. However, the Minimum Data Set resident assessment instrument, from which the data is obtained, is not Medicaid funded. The Department contracts with DPHE through an interagency agreement for these functions. Federal financial participation is broken into two categories: 1) expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals expenditures related to long-term care facilities, and 2) expenditures qualifying for a 50% federal financial participation rate to cover POTS and other Common Policies for the FTE that perform these services. While the DPHE FTE is working in the field to survey and inspect the facilities, that FTE qualifies for 75% federal financial participation. After the FTE returns to the office to complete the paperwork associated with the inspection, the FTE time in the office qualifies for 50% federal financial participation. The FTE uses a time reporting sheet that details how each hour of work is spent, so that Medicare and Medicaid funding can be claimed as applicable.

The federal Centers for Medicare and Medicaid Services (CMS) also requires that the State be in compliance with Medicare requirements for home health and licensure for hospice agencies. Facility surveys associated with compliance for these Medicare requirements are also performed by DPHE; however, they are Medicare funded rather than Medicaid funded.

TRANSFER FROM DHS FOR NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income (below 200% of the federal poverty level), first-time mothers with a baby less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

The trained visiting nurses educate mothers on the importance of nutrition and avoiding alcohol and drugs (including nicotine) and to assist and educate mothers on providing general care for their children and to improve health outcomes for their children. In addition, visiting nurses may help mothers to locate assistance with educational achievement and employment. This type of service is sometimes referred to as "targeted case management," involving a coordinated, ongoing, and personalized strategy for clients with a variety of needs, both medical and non-medical. Each unit of service provided equals 15 minutes and is rated and billed based on that timeframe.

The goals of the program are improvements in pregnancy outcomes and the health and development of their children, as well as long-term economic self-sufficiency of their families.

The Nurse Home Visitor Program received continuation funding in the FY 2013-14 Long Bill, SB 13-230. However, the arrangements for the funding, beginning in FY 2013-14 were changed by HB 13-1117. The program, previously funded through the Department of Public Health and Environment, will be funded going forward through the Department of Human Services. The Nurse Home Visitor Program will continue to provide services in a manner similar to when the program existed at the Department of Public Health and Environment. .

TRANSFER TO DPHE FOR PRENATAL STATISTICAL INFORMATION

The Department requires statistical data to evaluate the effectiveness of the Prenatal Plus program that used to be managed by DPHE but is now managed by the Department effective FY 2011-12. DPHE had been measuring the effectiveness of the program by using data supplied by the DPHE Vital Statistics office. The departments determined that it would be more cost-effective to continue to use the Vital Statistics data rather than to create a new tracking system for this purpose, so funding is allocated to reimburse DPHE for this purpose. This line item was newly established as a result of the Department's FY 2011-12 Budget Request DI-8 "Prenatal Plus Administration Transfer."

TRANSFER TO DORA FOR NURSE AIDE CERTIFICATION

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150(b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (DPHE). The Department provides Medicaid funding for the program and DPHE provides Medicare funding for the program. Pursuant to section 12-38-101, C.R.S., the Colorado State Board of Nursing in DORA oversees regulation of certified nurse aides practicing in medical facilities throughout the state. The regulation of nurse aides is carried out under the Nurse Aide Certification program, which includes a nurse aide training program, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

DORA is required to administer the Nurse Aide Certification program using established standards for the training curriculum to ensure that nurse aides receive federally required training and that nurse aides are tested regularly to assure competency. DORA is also responsible for administering a nurse aide registry program that allows investigations into allegations of abuse by nurse aides, when necessary. The registry also tracks the mandatory criminal background check required for nurse aides per the passage of HB 95-1266.

State funding for this program is comprised of General Fund and fees collected directly from nurse aides. These fees are assessed as part of the required criminal background check. Federal regulations prohibit requiring nurse aides to pay for certification, but requiring non-certified nurse aides to pay the cost of the background check is a permissible exception to these regulations. Many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements. The State funds, consisting of General Fund and reappropriated funds from DORA are used to draw down federal funds.

TRANSFER TO DORA FOR REVIEWS

The Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies (DORA) conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when the Department had a law requiring a sunset review, a specific line item was established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review.

This line item was established in the FY 2009-10 Long Bill Add-Ons (SB 09-259), beginning with FY 2008-09. The line item name was created to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a type of audit that are performed to provide information to the General Assembly on the effectiveness and efficiencies of particular programs. This information is used by the General Assembly to provide guidance on future legislation or modifications to current legislation. Statutory authority authorizing DORA to conduct these reviews comes from section 24-34-104 (8) (a), C.R.S. DORA calculates the anticipated costs for performing particular sunset reviews and notifies the Department by letter so that the costs can be requested in the future year budget submission for the Long Bill.

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

This line item funds a portion of the administrative expenses of the Public School Health Services Program created in SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers. Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. Pursuant to section 25.5-5-318 (8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. This line funds the administrative expenses of

the Colorado Department of Education, which provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. .

TRANSFER TO DOLA FOR HOME MODIFICATIONS BENEFIT ADMINISTRATION
This line item includes funding for the Division of Housing to administer the home modification benefit under the Elderly, Blind and Disabled, Spinal Cord Injury, Community Mental Health Supports, and Brain Injury Waivers. Funding ensures that bids for home modifications are correctly structured, and that home modifications are finished timely and meet housing codes.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS
Beginning with the FY 2013-14 Long Bill (SB 13-230), this line item was re-titled from "Information Technology Contracts and Projects: Information Technology Contracts" to "Medicaid Management Information Systems Maintenance and Projects." Before FY 2014-15, the Department made a distinction within this line item between funding for the Medicaid Management Information System (MMIS) contract and funding for the Provider Web Portal. This distinction was implemented through separate internal appropriation codes for the two functions (appropriation codes 142 and 149). Beginning in FY 2014-15, the Department ceased to make this distinction because it added administrative complexity that provided no practical value. Thus, the line item was consolidated to a single appropriation code (appropriation code 142).

The MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The MMIS processes claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from MMIS.

The Department has contracted with Xerox State Healthcare (formerly Affiliated Computer Systems (ACS)) to operate and develop the MMIS since 1998. Before the current vendor, Blue Cross Blue Shield was the MMIS and Fiscal Agent services vendor for 12 years.

The MMIS is federally required for states that participate in the Medicaid program (Section 1903(r) of the Social Security Act). The federal government pays 90% of the cost for designing, developing, or installing new functionality or components of the MMIS per 42 C.F.R. §433.15 (b)(3). They pay 75% of the cost for ongoing operations and maintenance of the MMIS per 42 C.F.R. §433.15 (b)(4). CMS's *State Medicaid Manual* identifies the specific types of MMIS costs that are allowable for federal reimbursement.

This line item also funds the development of and operations of the provider web portal, federally required under HIPAA. The web portal became operational in 2003 and provides a web application front-end for providers to submit HIPAA-compliant electronic transactions to and from the Medicaid Management Information System (MMIS), Colorado Benefits Management System (CBMS), and Benefits Utilization System.

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTED STAFF
With the Department's FY 2013-14 R-5 "MMIS Reprocurement," funding was approved over the course of four years beginning in FY 2013-14 to procure a new MMIS. In addition to the technology implementation costs associated with reprocurement, the proposed solution also requires temporary staffing to assist the Department during the implementation phase to avoid the costs and delays of a failed procurement seen in other states.

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTS
With the Department's FY 2013-14 R-5 "MMIS Reprocurement," funding was approved over the course of 4 years beginning in FY 2013-14 to procure a new MMIS. This line item was created to house approximately $93 million of the FY 2013-14 R-5 funding for contract costs related to the MMIS reprocurement. When the current MMIS and Fiscal Agent services contract ends in FY 2015-16, it must be competitively bid and reprocured in order to meet certain federal fiscal agent contracting requirements. Furthermore, the current highly outdated MMIS creates significant operational inefficiencies, limitations to the Department's ability to implement policy changes, and risks losing federal approval and federal financial participation (FFP), making reprocurement an opportunity to acquire a new, modern MMIS to address these problems.

FRAUD DETECTION SOFTWARE CONTRACT
On January 23, 2008, the Department submitted BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries," requesting $1,250,000 in total funding to increase efficiencies in Medicaid cost avoidances and provider recoveries. The approved budget amendment allowed the Department to purchase fraud-detection software and also allowed the Department to implement improvements to the Medicaid provider re-enrollment process.

The fraud-detection software utilizes neural network and learning technology to detect fraud, abuse, or waste in the Medicaid program. It also supports such functions as compliance monitoring, provider referrals, and utilization review. Moreover, it provides support to the Department's Program Integrity Section by providing additional research on: potential fraud and abuse; receiving and accessing licensing board data to compare with provider data; looking for known abusive or fraudulent practices using target queries on procedure or diagnosis codes; and, tracking the progress of individual cases, including case hours, investigative cost, and travel expenses related to the Medicaid program.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) for the implementation and administration of a centralized eligibility vendor model. It was the result of the recommendation by The Blue Ribbon Commission for Health Care Reform (the "208 Commission") created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal suggested creating a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility.

The Centralized Eligibility Vendor streamlines navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, creates expedited eligibility for medical only cases, and improves outreach and enrollment in both programs. These changes ensure easier, more reliable, and timely eligibility and enrollment processes, making the programs more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. In addition, the entity modernizes the current eligibility determination process by providing technology that is not currently available in every county, such as an automated customer contact center and an electronic document and workflow management system. This provides a central repository for applications and related documents. The Centralized Eligibility Vendor also provides electronic systems that aid in managing the online application for benefits. This entity enhances and complements the current multiple county-level process.

HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS

This line item was created in the FY 2014-15 Long Bill (HB 14-1336) to build infrastructure allowing for the secure and private exchange of electronic client health information among providers, labs, the Department, and other appropriate health care entities. The initial funding for this line item originated with the Department's FY 2014-15 R-5 Request "Medicaid Health Information Exchange."

Specifically, the Department is installing hardware and software infrastructure that allows Medicaid providers and hospitals to network together their individual electronic health record (EHR) systems. This allows for a client's EHR to be quickly called up and shared with any of the client's providers statewide when appropriate. This enables improved care coordination, better client experiences, better-informed care decisions, more opportunities for preventative care, and advanced analytics to help policy-makers. The Department works closely with the Colorado Regional Health Information Organization (CORHIO), which is the State-Designated Entity (SDE) in charge of coordinating electronic Health Information Exchange (HIE) statewide.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

The purpose of Medicaid identification cards is to provide proof of a client's Medicaid eligibility to service providers so that the client can receive medical services from the provider. Currently, if clients cannot show proof of Medicaid eligibility, providers can, at times, refuse to provide services.

Under the medical ID card system, clients are issued plastic Medicaid authorization cards upon a determination of their eligibility for Medicaid. Prior to rendering Medicaid services, providers must verify Medicaid eligibility electronically after viewing the client's plastic card. In the event plastic cards are lost, replacement cards are issued when necessary. The plastic authorization cards have reduced the Department's liability from a one-month guarantee of eligibility to only the exact periods of eligibility. The new cards also allow clients to move on and off covered programs without receiving a new card each time.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards, but, prior to FY 2003-04, there were no specific funds to pay for the production of these cards. Beginning in FY 2003-04, funding for authorization cards for the Old Age Pension State Medical Program's clients was added to the appropriation. Since these clients are not Medicaid eligible, no federal match is available for these funds.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for three Department functions: Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review (PASRR), and Hospital Outstationing.

Prior to FY 2008-09, Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations were funded through their own separate line items within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, HB 08-1375, the FY 2008-09 Long Bill consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The three budget items for Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, and School District Eligibility Determinations were combined into one line item titled "(D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations" within Long Bill group (1) Executive Director's Office. In FY 2009-10, School District Eligibility Determinations was eliminated pursuant to the Department's FY 2009-10 ES-3 "Department Administrative Reductions" and Hospital Outstationing was added as a result of the passage of HB 09-1293, "Colorado Health Care Affordability Act."

DISABILITY DETERMINATION SERVICES

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services (DHS) to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from DHS to the Department of Health Care Policy and Financing (the Department).

NURSING HOME PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) ASSESSMENTS

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this program is 75%.

All admissions to nursing facilities with Medicaid certified beds, regardless of individual payer source, are subject to preadmission screening, and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, that they remain in the nursing facility for the appropriate amount of time, and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

HOSPITAL OUTSTATIONING

This line item funds outstationing activities at hospitals in order for hospitals to provide certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the State's medical assistance programs. This line item was created as a result of the passage of HB 09-1293, the "Colorado Health Care Affordability Act," to assist with the anticipated increase in caseload due to the bill.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services (DHS) budget through an interagency transfer and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs administered by DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, thereby establishing a direct relationship between the Department and the counties performing these functions.

As part of the Department's fiscal note for SB 06-219, the Department and DHS agreed that the allocation and reimbursement methodology would remain the same as prior to July 1, 2006. This included: 1) using the existing federally-approved random moment sampling model performed by DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 2) continuing using a cost-sharing allocation; 3) continuing to utilize the County Financial Management System for counties to have one-stop billing; and, 4) utilizing interagency transfers of General Fund between the Department and DHS pursuant to 24-75-106, C.R.S. in order to maximize Medicaid reimbursement to the counties. Subsequent appropriations for County Administration have been made without including a local share; as a result, the state, county and federal share of the appropriation do not follow the traditional 30% General Fund, 20% local share, and 50% federal funds that were historically seen.

The General Assembly appropriated additional funding to this line item in SB 13-200, which authorized Medicaid expansion under the Affordable Care Act. Additionally, to meet the expected high demand for eligibility determination services, the Centers for Medicare and Medicaid Services (CMS) examined its current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and has confirmed that certain eligibility determination-related costs are eligible for 75% federal financial participation (FFP), which has reduced the state and federal share for certain activities that a reimbursed under this line item. Counties can access the enhanced funding through random moment sampling (RMS) or direct coding.

Additional funding was added to the line through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" to support infrastructure grants and incentive payment structure to counties. The infrastructure grants are expected to go to counties for one-time funding to improve the eligibility determination process. The incentive payment structure is expected to encourage faster and more accurate application processing and other process improvements in order to create a more efficient and effective eligibility determination process.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item provides for reimbursement to local county departments of human/social services for costs associated with performing Medicaid eligibility determinations for the "Expansion Adults to 100% Federal Poverty Level (FPL)" category funded under HB 09-1293, the "Colorado Health Care Affordability Act." This funding was included in the County Administration line item, showing up as Cash Funds and Federal Funds; however, the Department's FY 2012-13 S-7 "Hospital Provider Fee Administrative True-up," submitted with the January 3, 2012 Supplemental Budget Request, requested the separation of this funding, thereby establishing this line item to make the budget more transparent, allow for easier tracking of hospital provider fee funds, and to separate funding sources that are allocated based on differing methodologies. Subsequent appropriations, including those from SB 13-200, have expanded the use of this funding to other populations considered "newly eligible" under the Affordable Care Act.

While the County Administration line item reimburses county departments using a methodology including a random moment time study, a local funding match, and interagency transfers, this line item reimburses in a manner more reflective of the expansion of the Department's programs under HB 09-1293. Prior to FY 2014-15, these funds were distributed twice per state fiscal year based on total County Administration expenditures and each county's percentage of newly eligible clients funded by the Hospital Provider Fee relative to total Medicaid. Beginning in FY 2014-15, these funds will be blended into the regular county administration appropriation and distributed monthly through the normal county reimbursement methodology. By blending the two appropriations together, the Department is able to reduce the administrative burden of additional payment while assuring the counties receive funding in a timely manner.

MEDICAL ASSISTANCE SITES

This is a new line item in FY 2014-15 funded through the Department's FY 2014-15 R-6 "Eligibility Determination Enhanced Match" and will initially fund a review of eligibility assistance and determination sites in addition to funding Medical Assistance (MA) sites for their Medicaid eligibility determination activities.

This line item will fund MA sites to conduct Medicaid eligibility determination on location. MA sites offer additional points of contact for Medicaid eligibility determination and eligibility workers are stationed at places such as schools, clinics and hospitals in order to assist clients. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet and support the Department's aim to have "no wrong door" in determining client eligibility. Previously, MA sites were unfunded for their eligibility determination activities.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services (CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – Medicaid Funded Programs appropriations.

Funding for administrative case management includes reimbursement for staff and operating costs associated with State supervision and county administration of programs that protect and care for children, including out-of-home placement, subsidized adoptions, child care, and burial reimbursements. Medicaid funding for these costs was identified through a contingency based contract held between the Governor's Office of State Planning and Budgeting and Public Consulting Group, Inc.

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. Also similar to the County Administration appropriation, DHS has agreed to provide additional General Fund spending authority if necessary, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with this funding.

ACA IMPLEMENTATION, TECH SUPPORT, AND ELIGIBILITY DETERMINATION OVERFLOW CONTINGENCY

This line is a new and temporary line that was initially funded through the Department's FY 2013-14 1331 Emergency Supplemental "County Administration" and the FY 2014-15 R-6 "Eligibility Determination Enhanced Match." This line item funds call center and back office functions necessary for implementation of the Affordable Care Act and SB 13-200 "Expand Medicaid Eligibility."

The call center and back office functions exist to mitigate any issues with ACA implementation and support overflow from counties efforts in order to maintain application processing requirements, including timely filing requirements and telephonic recording of a verbal signature for phone applications. This line item also funds additional assistance to process data verifications and collection of household relationship data. This funding is only expected to be needed through FY 2014-15.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department functions: the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker. Prior to FY 2008-09, each of these functions was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office long bill group into a more programmatic format. As a result of HB 08-1375, the FY 2008-09 Long Bill, 46 line items were consolidated into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated budget items were the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker, which were combined into one line item titled "(D) Eligibility Determinations and Client Services: Customer Outreach" within Long Bill group "(1) Executive Director's Office."

<u>EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM</u>

The Department is required to ensure Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program outreach and case management services in a manner consistent with the federal regulations set forth at 42 CFR §§ 441.50-441.61. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services for children. The services include, but are not limited to:

- contacting eligible clients to provide in-depth explanation of the program and its importance within 60 days of eligibility being established;
- offering assistance and information to eligible clients and helping to overcome barriers which might impede access to services;

- clarifying the role of primary care providers, dentists, and the managed care/prepaid health plans;
- emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician;
- maintaining periodic contact with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed;
- initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring EPSDT clients as needed to those agencies and resources;
- assisting clients with the program and managed care information process; and,
- referring applicants to the enrollment broker at the time of Medicaid application.

Only administrative and outreach services are funded by this budget item. Services funded by this budget item are contracted primarily by county health department staff but may include other local outreach providers such as hospitals and community-based organizations. The funding for medical services provided through the EPSDT Program remain in the Department's Medical Services Premiums Long Bill group.

ENROLLMENT BROKER

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-05. The vendor contracted to serve as the enrollment broker is charged with providing information on basic Medicaid benefits offered through all health plans. In this, the vendor contacts all newly eligible Medicaid clients to inform them of Medicaid plan choices. If a client chooses the Primary Care Physician Program or a health maintenance organization, the vendor will enroll the client in the plan. The vendor also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. The enrollment broker vendor does this work under the name of Health*Colorado*. As of January 1, 2013, the enrollment broker vendor provides enrollment management services for the CHP+ program.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Acute Care Utilization Review, Long-term Care Utilization Review, External Quality Review, Drug Utilization Review and Mental Health External Quality

Review were combined into one line item titled "(E) Utilization and Quality Review Contracts: Professional Services Contracts" within Long Bill group (1) Executive Director's Office.

ACUTE CARE UTILIZATION REVIEW

Acute Care Utilization Review budget item includes the performance of prospective and retrospective reviews for specified services to ensure that requests for benefits are a covered benefit and that the service is medically necessary and appropriate. Prospective reviews are conducted prior to the delivery of services and include the following service categories: transplants; select procedures; out-of-state elective admissions; inpatient mental health services; inpatient substance abuse rehabilitation; durable medical equipment; select non-emergent medical transportation; Early and Periodic Screening, Diagnosis and Treatment home health service reviews; and, outpatient physical and occupational therapy requests. Retrospective reviews are conducted on inpatient stays after the hospital claims have been paid. By examining the paid claims against the medical records, the contractor ensures the care paid for was medically necessary, required an acute level of care, and was coded and billed correctly.

The Department contracts with an independent contractor to perform prospective and retrospective reviews. These reviews result in cost avoidance and recovery of provider payments should the provider or facility fail to provide the required documentation. Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 C.F.R. §433.15 (6)(i), the Department is allowed to request enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization as defined under Section 1152 of the Social Security Act.

LONG-TERM CARE UTILIZATION REVIEW

Long-term care utilization reviews include performing prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reevaluation of services. In addition, the Single Entry Point (SEP) agencies (case management agencies and community-centered boards) perform pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community-based long-term care programs, as well as annual continued stay reviews of these clients. The SEP agencies and other contractors perform the following functions with funding from this budget item:

- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Pre-Admission Screening and Resident Review (PASRR Level I) to identify clients who need Level II screening;
- administration of the Hospital Back-Up (HBU) Program, which provides cost-effective alternatives for clients who have extended acute hospitalizations by permitting transfer to nursing facilities capable of providing care;
- assessments for the Children's Extensive Support (CES) waiver which provides Medicaid benefits, services and support for children with developmental disabilities or delays and require special services and provide an alternative to institutional placement;
- assessments for Private Duty Nursing which provides eligible clients with skilled nursing services in a home setting;

- data management; and,
- training for case managers.

The Department's contractor maintains a long-term care database and performs prior authorization reviews for long-term care clients. The results of the prior authorization reviews are transmitted electronically to the Department's fiscal agent. The contractor also conducts reviews for the Level II PASRR Program.

The Department received enhanced federal funding for a number of activities performed in this line item. Under Section 1903 (a)(2)(C) of the Social Security Act and 42 C.F.R. §433.15 (9), the Department is allowed to request enhanced federal financial participation of 75% for funds expended to conduct preadmission screening and resident review activities. If a contractor qualifies as a qualified improvement organization under Section 1152 of the Social Security Act, the Department may seek enhanced federal financial participation of 75% for the performance of medical and utilization review activities other than preadmission screening and resident review.

EXTERNAL QUALITY REVIEW

This budget item provides funding for the Department's contractor Health Services Advisory Group, Inc. to validate performance improvement projects and Healthcare Effectiveness Data and Information Set (HEDIS) measures for managed-care organizations, the Primary Care Physician Program, and fee-for-service providers. Health Services Advisory Group, Inc. also provides an annual report of activities and recommendations. The contractor is responsible for the day-to-day administration and management of a credentialing program for Medicaid providers. The process includes, but is not limited to:

- collection and verification of the status of licensure;
- validation of Drug Enforcement Agency or Controlled Dangerous Substances certification;
- verification of relevant training, experience, and board certification;
- maintenance of records on any past liability claims;
- tracking of U.S. Department of Health and Human Services, Medicare and Medicaid sanctions; and,
- verification of work history.

Through the credentialing process, the contractor verifies the credentials of approximately 33% of the primary care providers enrolled in the Primary Care Physician Program each year (up to 380 annually) and 20 primary care providers enrolled in the Self-Insured Network, plus new monthly enrollments. The credentialing process helps the Department identify quality of care issues, fraudulent representation, loss of privileges, and licensure revocation or illegal practices which require further investigation. If such actions from physician regulatory boards have been recommended, the Department staff suggests further actions that may include termination of Medicaid participation. Beginning in FY 2012-13, the Department's contract with Health Services Advisory Group is amended to

include conducting survey administration, analysis, and reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (Children with Chronic Conditions-Plan Specific), for six CHP+ plans.

The Department is permitted to receive an enhanced federal financial participation rate of 75% for funds expended for performance of external quality review or related activities when they are conducted by an external quality review organization as defined in 42 C.F.R. §438.320 and 42 CFR §433.15 (b)(10).

DRUG UTILIZATION REVIEW

This budget item funds the Department's drug utilization review program established pursuant to 42 C.F.R. §456.703. The purpose of the program is to ensure appropriate drug therapy while permitting sufficient professional prerogatives to allow for individualized drug therapy. The program consists of both prospective and retrospective reviews, the application of explicit predetermined standards, and an educational program. Pursuant to 25.5-5-506 (3) (b), C.R.S., the Department submits an annual report to the Health and Human Services Committees of the General Assembly that contains:

- information on the prospective and retrospective drug review program;
- the steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards;
- a summary of the educational interventions used and an assessment of the effect of these educational efforts on quality of care; and,
- an estimate of the cost savings generated as a result of the drug use review program.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item funds various audit contracts managed by the Department. Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Nursing Facility Audits, Hospital and Federally Qualified Health Clinics Audits, Single Entry Point Audits, Payment Error Rate Measurement Contract, and Nursing Facility Appraisals were combined into one line item titled "(F) Provider Audits and Services: Professional Audit Contracts" within Long Bill group (1) Executive Director's Office. The budget item Colorado Indigent Care Program Auditor was later added as a result of HB 09-1293 "Health Care Affordability Act," and the budget item Disproportionate Share Hospital (DSH) Audits was added as a result of the Department's FY 2010-11 DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures."

NURSING FACILITY AUDITS

This budget item funds statutorily required audits of costs reported by Medicaid nursing facilities for rate setting purposes. The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient-related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes.

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CENTERS AUDITS

This budget item funds a Department contract with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers (FQHCs), and rural health centers that participate in the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and participation in meetings with providers to resolve problems. The annual rates of reimbursement are based on the results of these audits and are set to cover the reasonable and necessary costs of an efficiently run hospital, FQHC, and rural health center, per federal and State law.

SINGLE ENTRY POINT AUDITS

This budget item funds annual audits of single entry point (SEP) agencies provided through a contractor. The scope of work has been limited to reviews of cost reports. To the extent that funds allowed, on-site audits are conducted for agencies that posed the highest risk. In FY 2006-07, the appropriation to this line was increased in order to increase the accuracy of SEP agency billing and potentially increase recovery of improper payments.

PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT

This budget item funds the Payment Error Rate Measurement Project, which was established in response to the federal Improper Payments Information Act of 2002 and was the culmination of three separate federal pilot programs collectively referred to as the Payment Accuracy Measurement Projects. The federal Improper Payments Information Act of 2002 requires the Department to: conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments; estimate the amount of improper payments made; and, report on those estimates. The Improper Payments Information Act of 2002 defines an improper payment as "any payment made that should not have been made or that was made in an incorrect amount including overpayments and underpayments." The definition further states that these payments "include any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and, any payment that does not account for credit for applicable discounts."

In August 2006, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule stating that federal contractors would be hired to calculate national error rates and review states' fee-for-service and managed care payments for Medicaid and State Children's Health Insurance Programs. Under the rule, each state is required to calculate its state-specific eligibility error rates and measure improper payments once every three years, so that all states are reviewed on a rotating basis, with 17 states reviewed per federal fiscal year. Due to the three-year cycle, Colorado completed the eligibility and payment error reviews in FY 2010-11 and will do so again in FY 2013-14.

Under the Payment Error Rate Measurement project, reviews are conducted in three areas: fee-for-service, managed care, and eligibility for both Medicaid and Children's Basic Health Plan. The claims review is conducted by federal contractors, whereas the eligibility review is conducted by the states. The results of these reviews are used to produce national program error rates as well as state-specific program error rates.

NURSING FACILITY APPRAISALS

This budget item funds nursing facility appraisals, which occur once every four years. The Department contracts with an independent firm to conduct these appraisals, with the underlying result being the determination of "fair rental value." Fair rental value, or appraised value, means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental (property) value determination is used in the process of rate setting, which is governed by statute at 25.5-6-201, C.R.S. The per-diem rate paid to nursing facilities is based in part on the fair rental value of the facility.

COLORADO INDIGENT CARE PROGRAM AUDITOR

This budget item funds an auditor for the Colorado Indigent Care Program due to the passage of HB 09-1293 "Heath Care Affordability Act." Prior to this passage of this bill, the providers were paid using certification of public expenditures in order to draw federal matching funds. The Department currently contracts with a certified public accounting firm to perform federally mandated cost and rate data audits for hospitals, federally qualified health clinics, and rural health centers that participate in Medicaid. The certified public accounting firm establishes reimbursement rates, reviews contracts, calculates final cost settlements, rebases calculations, consults and assists on cost report interpretations, and meets with providers to resolve discrepancies. Prior to the passage of HB 09-1293, the Department did not perform such audits for providers participating in the Colorado Indigent Care Program. However, due to HB 09-1293, reimbursements for providers participating in the program are to be increased to 100% of cost, requiring similar audits to be conducted for the Colorado Indigent Care Program providers.

Through this budget item, the Department will utilize two types of audits to ensure proper payment of hospital fee funds to Colorado Indigent Care Program providers. The first are desk audits to: analyze cost reports to determine the accuracy and reasonableness of financial data reported by providers; identify problem areas that warrant additional review; and, obtain information for use in planning

a site audit if deemed necessary. Second are on-site audits that will focus on specific payment issues that are potentially material in nature and a more detailed verification of data than the desk audit.

DISPROPORTIONATE SHARE HOSPITAL AUDITS

This budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures" (November 2, 2009 FY 2010-11 Budget Request). This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

DSH payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients. These payments assist in securing the hospitals' financial viability and preserving access to care for Medicaid and low-income clients, while reducing the shift in costs to private payers. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, established by HB 91S2-1030 and authorized in 25.5-4-302, C.R.S., is operated by a contractor under supervision of the Department. The contractor pursues recoveries on a contingency fee basis and recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. Since FY 2003-04, the contractor has charged a contingency fee of 10.9%, with the remainder of the recoveries acting as an offset to expenditure in the Medical Services Premiums line.

(H) STATE OF HEALTH PROJECTS

PAIN MANAGEMENT CAPACITY PROGRAM

This line item resulted from the passage of HB 14-1336, the FY 2014-15 Long Appropriations Bill. It was created to fund pain management training for physicians and providers, which the Department is undertaking through the Accountable Care Collaborative (ACC) program with various options including a Project Extension for Community Healthcare Outcomes (ECHO) program that provides online and phone conference pain management training for providers.

DENTAL PROVIDER NETWORK ADEQUACY
This line item resulted from the passage of HB 14-1336, the FY 2014-15 Long Appropriations Bill. It was created to promote growth of the Medicaid dental provider network as part of the new comprehensive Medicaid dental program. Dental providers will receive enhanced payments for treating at least 5 new Medicaid clients within FY 2014-15.

(I) INDIRECT COST RECOVERIES

INDIRECT COST ASSESSMENT
This line item resulted from the passage of SB 13-230, the FY 2013-14 Long Appropriations Bill. It was created to separately identify the overhead costs associated with the operation of general government functions. Indirect cost recoveries are intended to offset these overhead costs that otherwise would have been supported by the General Fund, from cash and federally funded sources. Recoveries from cash and federally-funded programs are calculated for statewide overhead costs by the Office of the State Controller.

(2) MEDICAL SERVICES PREMIUMS

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. Medical services are grouped into the following categories, each of which include several programs: acute care, community-based long-term care, and long-term care. Additional expenditures are incurred for insurance, service management, and financing payments. For a program-level description of each of the aforementioned categories of services, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-1, "Request for Medical Services Premiums."

To calculate the funding need for the Medical Services Premiums Line, the Department must forecast Medicaid caseload. In past years, the caseload forecast was included in the Line-Item Description. This year, the caseload presentation is included in the budget request as a separate exhibit. For a detailed narrative of the caseload forecast, please see the "Medicaid Caseload" Section included in this budget submission.

(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS

BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed-care providers contracted by the Department. The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

(4) OFFICE OF COMMUNITY LIVING

In 2012, Governor Hickenlooper issued Executive Order D 2012-027, establishing the Office of Community Living within the Department. The Office is charged with better aligning services and supports so that people with long-term services and supports needs, and their families, do not have to navigate a complicated and fragmented health care system. HB 13-1314, "Transfer Developmental Disabilities to HCPF" transferred funding from the Department of Human Services to the Department effective March 2014; this Long Bill group was established with the FY 2014-15 Long Bill (HB 14-1336).

The Office of Community Living Long Bill group of the Department's budget contains the administrative and programmatic funding for services and supports for persons with Intellectual and Developmental Disabilities and their families. Funding extends to FTE, operations support for a standalone case management system, and services and supports for eligible individuals and their families.

(A) DIVISION OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

(1) ADMINISTRATIVE COSTS

PERSONAL SERVICES
This line item funds the Department's expenditures for FTE and temporary staff who work in the Division of Intellectual and Developmental Disabilities. It was created as part of HB 13-1314 "Transfer Developmental Disabilities to HCPF", which transferred the administration of long-term services for persons with intellectual and developmental disabilities to the Department. Allocated POTS for the FTE, including Salary Survey, Merit Pay, Health, Life, Dental, Short-Term Disability, Supplemental Amortization Equalization Disbursement, and Amortization Equalization Disbursement, are paid through this line item.

OPERATING EXPENSES
In addition to funding telephones, computers, office furniture, and employee supplies associated with the Division's staff, this line also supports a number of annual costs such as in- and out-of-state travel, records storage, postage, costs, and subscriptions to federal publications.

COMMUNITY AND CONTRACT MANAGEMENT SYSTEM
Service providers assisting HCBS-SLS and HCBS-DD waiver clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level

evaluations. This line funds 70% of the costs for the Community and Contract Management System (CCMS), which is used to authorize services, bill for services, and collect demographic data for people with intellectual and developmental disabilities. The CCMS also tracks disability resources and contracts, as well as waiting list information. This line funds approximately 95% of operating expenses and 100% of the support level administration costs.

SUPPORT LEVEL ADMINISTRATION
Service providers assisting HCBS-SLS and HCBS-DD waiver clients are paid rates based on each individual's evaluated support level. In turn, the support level is based primarily on the Supports Intensity Scale (SIS) assessment tool, which has been in use since 2009. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's support level. Community Centered Boards are reimbursed for the administration of the SIS and support level evaluations.

(2) PROGRAM COSTS

ADULT COMPREHENSIVE SERVICES
Funding supports the HCBS-DD waiver, which provides services and supports to persons with intellectual and developmental disabilities, allowing them to continue to live in the community, yet within a 24-hour care model. Services provided under this waiver include: day habilitation; prevocational; residential habilitation; supported employment; dental; vision; behavioral services; non-medical transportation; and specialized medical equipment and supplies.

ADULT SUPPORTED LIVING SERVICES
This line provides funding for the HCBS-SLS waiver and the State Supported Living Services option.

The HCBS-SLS waiver provides supported living in the home or community to persons with intellectual and developmental disabilities. Services include: day habilitation; homemaker; personal care; prevocational; respite; supported employment; dental; vision; assistive technology; behavioral services; home accessibility adaptation; mentorship; non-medical transportation; personal emergency response systems; professional therapeutic services; specialized medical equipment and supplies; and vehicle modification.

The State Supported Living Services option provides the same service array as the HCBS-SLS waiver, but is available to individuals who do not meet Medicaid eligibility requirements. State Supported Living Services are locally administered by the Community Centered Boards. Individuals receiving services must not need 24-hour program support. Services are funded with General Fund

CHILDREN'S EXTENSIVE SUPPORT SERVICES
The HCBS-CES waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's intellectual or developmental disability. Services include: homemaker; personal care, respite, vision, adapted and therapeutic recreation equipment; assistive technology; behavioral services; community connector; home accessibility adaptation; professional therapeutic services; specialized medical equipment and supplies; vehicle modifications; and youth day services.

CASE MANAGEMENT
This line funds 20 Community-Centered Boards (CCBs) to provide case-management, utilization review/quality assurance (UR/QA), and Pre-Admission Screening and Resident Reviews (PASRR) to clients throughout the State. Reimbursement for PASRR is only for Level II screenings, which ensures that individuals meet federal criteria for appropriateness of care delivered in a Nursing Facility, as well as determining if they need specialized services. Case Management is provided for the three HCBS waivers, the State Supported Living Services delivery option, the Family Support Services Program, and the Family Support Loan Fund. Waiver services are delivered through community providers, including CCBs and two state-operated regional centers. Case Management services are currently appropriated for approximately 11,342 Medicaid clients under the consolidated line item. Targeted Case Management is billed fee-for-service rates.

FAMILY SUPPORT SERVICES
The Family Support Services line provides financial support for families who have children, including adult children, with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The primary purpose of the Family Support Services Program is to keep families together in the family home. In order to qualify, a family must have an eligible child living at home or be interested in facilitating a child's return to the home. Examples of services include: medical and dental expenses, additional insurance expenses, respite care and childcare, special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services.

PREVENTIVE DENTAL HYGIENE
This line item supports outreach services to match individuals needing dental care with dentists willing to provide pro-bono dental care. Funding also goes to train clients receiving developmental disability services and staff about preventive dentistry and to educate both populations about how to access dental care.

ELIGIBILITY DETERMINATION AND WAITING LIST MANAGEMENT
This line provides reimbursement to Community-Centered Boards (CCBs) for administrative functions, including determination of intellectual and developmental disability. In addition, CCBs are reimbursed for management of the waiting list for the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver.

(5) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department budget consists of the Colorado Indigent Care Program, the Primary Care Fund Program, the Children's Basic Health Plan, and other Safety Net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program is presented below.

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides funding to hospitals and clinics that have uncompensated costs from treating underinsured or low-income uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. For FY 2014-15, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; the Primary Care Fund Program; and, Pediatric Specialty Hospital. These line items allow providers to receive partial compensation for uncompensated costs due to services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, the Colorado Indigent Care Program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the program increased from 185% to 200% of the federal poverty level effective February 1, 2006 due to the expansion populations created under HB 05-1262. On July 1, 2006, the financial eligibility requirement was further increased to 250% of the federal poverty level per SB 06-044. The program contracts directly with hospitals and community health clinics to provide specific services to eligible individuals. By statute, providers are required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and, 3) any other medical care as financing allows. Providers are required to provide on-site eligibility and co-payment determinations. To determine eligibility, providers assign a rating to applicants based on their total income and assets. Nearly all clients are required to pay a minimal annual co-payment, which varies according to services received and client rating. For all client ratings except the N-rating (0-40% of the federal poverty level), annual co-payments cannot exceed 10% of the family's total income and equity in assets. The annual co-payment for clients with an N-rating cannot exceed $120.

The majority of the program is supported by two sources of federal financial participation: Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limit (UPL). Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for

federal matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and cash funds to draw down these federal funds, although the contribution of General Fund dollars to the state match is minimal relative to more innovative sources of state funds. Prior to FY 2009-10, the State utilized certification of public expenditures for all publicly-owned facilities (seen as cash funds in the budget) to draw down matching federal funds. Beginning in FY 2009-10, the use of certification has been replaced with fees assessed on hospital providers. Any provider who participates in the program is qualified to receive funding from the DSH Allotment and the Medicare UPL. See the "Safety-Net Provider Payments" line item for more detail about funding mechanisms.

As required by HB 04-1438, the Department must include in the annual Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. This information can be found in Exhibit K in the Department's November 1, 2014 FY 2014-15 Budget Request.

SAFETY NET PROVIDER PAYMENTS

The Safety Net Provider Payments line item was added to the Indigent Care Program Long Bill group following the passage of SB 03-258, the FY 2003-04 Long Bill. The Department's FY 2003-04 DI-6 "Change Methodology for Financing the Indigent Care Program and Disproportionate Share Hospital Through Proposed Safety Net Funding Allocation" submitted with the November 1, 2002 Budget Request requested the consolidation of the following line items into the new Safety Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could more easily be understood by Department staff, the General Assembly, and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved, providing increased overall payments to qualified providers.

Prior to FY 2009-10, the Safety Net Provider Payments line item was composed of four payments: Low-Income, Bad Debt, High-Volume, and Medicaid Shortfall. However, HB 09-1293 combined the Low-Income, Bad Debt, High Volume, and Medicaid Shortfall payments into two more broadly-based supplemental payments to CICP providers: the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment. A summary of the rules related to the reimbursement of Safety Net providers under these two payments is given in the following matrix.

Payment Type	Public Hospitals	Private Hospitals
CICP Disproportionate Share Hospital Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital federal funds limit imposed by federal law.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share of payments is from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share of payment is from Disproportionate Share Hospital federal funds.
CICP Supplemental Medicaid Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share is from the federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share is from the federal Medicaid matching rate for Colorado.

Under the distribution model, CICP hospital providers are reimbursed up to 100% of uncompensated costs associated with treating indigent clients funded in sum by two separate payment calculations (CICP Disproportionate Share Hospital Payment and CICP Supplemental Inpatient Hospital Medicaid Payment). Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital or Upper Payment Limit for inpatient hospital services funds. Both of these allocation types have limits that restrict the amount of federal match available.

Under the Disproportionate Share Hospital payments, the total federal amount made available is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type.

The Upper Payment Limit for inpatient hospital services is determined on a hospital-by-hospital basis and aggregated by hospital type: state-owned public hospitals, non-state owned public hospitals, and private-owned hospitals. Total inpatient hospital expenditures cannot exceed the available aggregated Upper Payment Limit by type. The CICP Supplemental Inpatient Hospital Medicaid Payment is funded by assessed hospital provider fees and federal matching funds under the available Upper Payment Limit for inpatient hospital services.

CLINIC-BASED INDIGENT CARE

The Clinic Based-Indigent Care line item was created in FY 2002-03 utilizing the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment because the hospital is privately owned. Being privately owned, the certification of public expenditures for uncompensated Medicaid costs is not allowed. Instead, General Fund is required to draw down

the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to participating clinics. The $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to participating clinics is based on a percentage of uncompensated indigent care costs relative to uncompensated costs reported by all recipients as reported in the Colorado Indigent Care Program Annual Report, increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005, to provide funding to the State's only pediatric specialty hospital, The Children's Hospital, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In 2005, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% should be appropriated to the General Fund.

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers serving indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other Department criteria. The fund was authorized under Section 24-22-117 (2)(b), C.R.S., and distributes funds generated from Amendment 35 (Tobacco Tax) to the providers based on the portion of medically indigent or uninsured patients they served relative to the total number of medically indigent or uninsured clients served by all qualified providers. To be a qualified provider, an entity must:

- accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge;
- serve a population that lacks adequate health care services;
- provide cost-effective care;
- provide comprehensive primary care for all ages;
- screen and report eligibility for the Medical Assistance Program, Children's Basic Health Plan, and the Indigent Care Program; and,
- be a federally qualified health center per Section 330 of the federal Public Health Services Act **or** have a patient base that is at least 50% uninsured, medically indigent, a participant in Children's Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 185% of the federal poverty level (FPL). The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. A dental benefit, offered in a capitated managed care environment, was added for children in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes under 185% FPL. To participate in the plan, families with incomes over 150% FPL (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. All State expenditures for benefits are matched with 65% Title XXI federal funds up to the federal allocation available. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund. However, there is no federal financial participation on the annual enrollment fees collected from families. Based on a memorandum of understanding with the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched differently than the normal 65% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures.

Until FY 2010-11, the Children's Basic Health Plan consisted of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in FY 2000-01, per Supplemental Bill SB 01-183, the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs. In the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental Costs.

In November 2004, the voters of Colorado approved Amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The legislation provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% FPL effective July 1, 2005. The legislation

also provided funding for cost-effective marketing, which began April 1, 2006. Funding was also provided to remove the Medicaid asset test, which became effective July 1, 2006.

In 2007, the Colorado Legislature passed SB 07-097, which expanded eligibility in the Children's Basic Health Plan to children and pregnant women with family incomes up to 205% FPL. Eligibility in the Children's Basic Health Plan was further expanded to 225% of the FPL in 2008 with the passage of SB 08-160. This eligibility expansion was suspended in SB 09-211 due to budget constraints.

Governor Ritter signed HB 09-1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee to increase eligibility in Medicaid and the Children's Basic Health Plan, as well as increase hospital reimbursement. As part of the Act, eligibility in the Children's Basic Health Plan was increased to 250% FPL on May 1, 2010.

During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation rate for their expenditures; however, the enhanced match for pregnant women is available only until FY 2015-16. The Department has received approval from the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients enrolled in the Children's Basic Health Plan. Auxiliary administrative functions are contracted out separately to various vendors for professional services such as actuarial analysis, claims audit, and quality assurance. The actuarial analysis is used to update capitation rates and project claims that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services collect Health Plan Employer Data and Information Set (HEDIS) quality data. Beginning in FY 2012-13, the Department also administers, analyzes, and reports results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as required by the Children's Health Insurance Program Reauthorization Act of 2009.

Under federal law, children eligible for Medicaid may not enroll in the Children's Basic Health Plan, yet many of the children who apply for the Children's Basic Health Plan are determined to be Medicaid-eligible. Thus, much of the costs of eligibility processing and

enrollment functions provided by the Children's Basic Health Plan's primary administrative services contractor are attributable to the Medicaid Program. Based on a study that identified the portion of workload generated by Medicaid, the Department and the Centers for Medicare and Medicaid Services have agreed upon a cost allocation methodology for charging costs to the correct program. The following table illustrates Colorado's cost allocation matrix used for determining which federal funds related to administration of the Children's Basic Health Plan are reimbursed by Medicaid, Title XIX of the Social Security Act, and which are reimbursed by the State's Child Health Insurance Program, Title XXI of the Social Security Act. The federal financial participation for the Medicaid program is 50% and that for Title XXI is 65%. Note that while total federal funds are referenced in legislative appropriation clauses, the share of Title XXI and Title XIX is not.

Cost Allocation Plan for Federal Funds		
Administrative Function	**Share of Funds at Title XXI Federal Match**	**Share of Funds at Title XIX Federal Match**
Marketing and Outreach Component	77.3%	22.7%
Eligibility and Enrollment Component	12.0%	88.0%
Professional Services and Other Administration Component	100.0%	0.0%
Children's Basic Health Plan Prenatal and Delivery Components	100.0%	0.0%

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

This line item was created during the Department's Supplemental Hearing on January 19, 2011, by the Joint Budget Committee (JBC) Staff as the combination of the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items. The costs of medical and dental services provided to eligible children and medical premiums for prenatal and delivery services for pregnant women enrolled in the Children's Basic Health Plan are funded through this line item beginning in FY 2010-11.

(6) OTHER MEDICAL SERVICES

The Other Medical Services section of the Department's budget contains funding for programs not administered by the Department through the Medicaid or Indigent Care programs. Some of the line items receive federal Medicaid funding but are administered by other departments, Commissions, or hospitals. This long bill group also contains funding for the Old Age Pension State Medical Program and the Medicare Modernization Act of 2003 State Contribution Payment. A description of each program is presented below.

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical and dental care for non-Medicaid-eligible individuals receiving Old Age Pension grants. This program is 100% State-funded and is not a federal entitlement. Eligible recipients are over the age of 64 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the constitution and supplemental General Fund appropriations to ensure adequate funding.

The Old Age Pension program was established in 1936 by an amendment to the State constitution, creating Article XXIV. This article was amended in 1956 to add the Old Age Pension Health and Medical Care Program and Fund in Section 7. Old Age Pension benefits specified in Article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits.

Both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S., was transferred to the Department from the Department of Human Services, effective July 1, 2003. Beginning in FY 2003-04, this line item was placed in the (5) "Other Medical Services" Long Bill group. The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The program is administered by the Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center. Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education, however, beginning in FY 1994-95, federal regulations allowed a federal financial participation rate of 50%. Since federal Medicaid funds were involved, a line item appropriation to the Department was established. Also, effective July 1, 2013, a privately-owned hospital that receives Family Medicine Residency

Training program payments is eligible to receive additional funds for the development and maintenance of family medicine residency training programs in rural areas.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of Denver Health and Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the legislation allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses Denver Health and Hospital Authority for Graduate Medical Education in two ways. First, fee-for-service payments to Denver Health and Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, Denver Health and Hospital Authority also receives lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Costs incurred by Denver Health and Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums line item. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority" line item.

STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of the University of Colorado Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the bill allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses the University of Colorado Hospital Authority for Graduate Medical Education in three ways. First, fee-for-service payments to University of Colorado Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, lump sum payments are also received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Third, the University of Colorado Hospital Authority receives funding for one of nine family medicine residency training programs administered by the Commission on Family Medicine, namely A.F. Williams Family Residency. Costs incurred by the University of Colorado Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums and Other Medical Services; University of Colorado Family Medicine Residency Training Programs line items. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority" line item.

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT

On January 1, 2006, the Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit, replacing Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the obligation of states to cover prescription drugs for this population, the Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. This is known as the "clawback" payment. For calendar year 2006, states were to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passes, the 90% factor is reduced, or "phased down," by 1.67% each year, until it reaches 75% in 2015, where it will remain on a go-forward basis.

The funding source for this line item is entirely state funds that do not receive federal matching funds; however, since FY 2010-11, there were federal funds appearing in this line. The federal funds that are appropriated to this line item are funds the State received as a bonus payment under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. The State had discretion in how it used those funds. In this case, this bonus payment provided General Fund relief in this line item. FY 2014-15 is the last year the State will receive CHIPRA Bonus funding, as the program expired at the end of federal fiscal year 2013.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

This line item was created with the approval of the Department's S-9, BA-7 "Public School Health Services Administrative Claiming" during the FY 2010-11 budget cycle. The Public School Health Services Program uses Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers.

The line item contains all administrative funding for the program excluding the Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System (MMIS). Funding for this line consists of a transfer of spending authority from the "(6) Other Medical Services; Public School Health Services" line item. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

PUBLIC SCHOOL HEALTH SERVICES

The Public School Health Services program began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. The Department pays for claims processing, personnel, and contracting costs. The Department of Education provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. The costs incurred by the two departments for administration are deducted from the federal matching funds. Pursuant to 25.5-5-318 (8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's budget is for Medicaid funding for services provided or administered by the Colorado Department of Human Services (DHS). Programs include services for persons with developmental disabilities, high-risk (substance abuse) pregnant women, individuals with mental health needs, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. DHS also receives the Department's share of the costs to support the Colorado Benefits Management System (CBMS) and other information technology support, as well as operations costs separately accounted for but related to the other groups of clients mentioned above. Medicaid funds for these programs are transferred from the Department to DHS as reappropriated funds. Although the funds are considered reappropriated from the perspective of DHS, the funding sources for these transfers from the Department are General Fund, federal funds, and cash funds.

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the DHS appropriations into 18 separate line items to improve expenditure tracking and reconciliation. These lines have changed over time, and there are currently 22 line items in the Department's budget within the DHS Medicaid-Funded Long Bill group. A description of each of the line items currently within the Department's budget follows.

All funding requests in this Long Bill group except one (Regional Center Depreciation) originate with DHS, and any inquiries related to the Department's Budget Request should be directed to DHS. The Department of Health Care Policy and Financing is a financing agency for these appropriations, meaning that the Department must validate the DHS funding request is for a Medicaid-allowable purpose as outlined by the federal Centers for Medicare and Medicaid Services (CMS). This Department also performs general oversight of the Medicaid-funded programs to ensure adherence to federal regulations for use of the Medicaid funds.

(A) EXECUTIVE DIRECTOR'S OFFICE – MEDICAID FUNDING

The Executive Director's Office is responsible for the general policy of the Department of Human Services (DHS) and contains staff and associated resources for implementing policy. This appropriation in the Department's budget includes Medicaid funding for two sections in the DHS budget: General Administration and Special Purpose. Because the Executive Director's Office includes a wide range of elements, the authorizations in the Colorado Revised Statutes are also varied. The main authorization is 24-1-120, C.R.S.

General Administration includes the DHS Executive Director and associated administrative staff, including the Department's budget staff, the Public Information Officer, the Legislative Liaison, and the Division of Field Administration that includes the County Commissioner Liaison. These staff members are FTE at DHS, but several of them also perform services related to Medicaid, so part of their salaries and related expenses are reimbursed by the Department.

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING

Many of the staff members for the Office of Information Technology have been transferred to the Governor's Office of Information Technology as part of the ongoing reorganization of information-technology services for Colorado State Government. However, some of the budget lines remain at the Department of Human Services (DHS) or the Department in order to access federal funding for the particular projects. The budget line items discussed in this section utilize federal Medicaid funding.

COLORADO BENEFITS MANAGEMENT SYSTEM

The Colorado Benefits Management System (CBMS) tracks client data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. There is no specific authorization in statute that specifically mentions CBMS; however, authorization can be inferred from 26-1-112, C.R.S.

Prior to February 15, 2007, the development and operational phases of CBMS were overseen by three state agencies: the Governor's Office of Colorado Benefits Management System, DHS, and the Department. CBMS replaced the following six legacy systems: Client Oriented Information Network; Colorado Automated Food Stamps System; Colorado Automated Client Tracking System; Colorado Adult Protection System; the Children's Basic Health Plan eligibility determination system; and, Colorado Employment First. During the development phase of the system and the early years after implementation of the system, the Department's appropriation reflected a fraction – roughly 34.71% – of total costs. Because CBMS handles clients enrolled in programs that receive varying levels of federal participation rates, the CBMS calculator was developed to allocate costs among the various programs. Expenditures are currently divided between the Department and DHS based on the calculator, which has been revised to reflect the division of work resulting from polling of the county departments of human/social services according to the Random Moment Sampling methodology that has become accepted by the Department and DHS as well as federal regulators. The Department's appropriation since FY 2008-09 reflects 38.31% of the total costs of the system, as indicated by the last major change in percentages reflected in the Random Moment Sampling results; the remaining percentage of expenditures is paid from the appropriation to DHS. When future Random Moment Sampling results reflect another major change in percentages, both departments anticipate a change in funding will be requested through the normal budget-request processes. Certain additional line items related to CBMS have various percentages of reappropriated funds because the other line items came into use during a fiscal year when the Random Moment Sampling results reflected different distributions of percentages.

A private vendor has been contracted to perform the major operations for CBMS from the beginning of the project. In August 2008, management and operation of the system was reprocured, and Deloitte Consulting LLP (Deloitte Consulting) was awarded the new contract. Deloitte Consulting took over full responsibility for operation of the system on April 1, 2009.

A broad range of components are paid from the appropriation for CBMS. Besides contracted payments to the vendor, the following items are also paid from the appropriation: computer hardware maintenance and repairs; computer software maintenance and upgrades; non-computer equipment rental; building rental; parking-fee reimbursement for staff at a different work location; rental of computer network equipment; rental of personal computers used in the office of the project (avoids purchase of the personal computers); in-state travel for providing training to county departments; other travel expenditures; telecommunication services; printing and reproduction of paper documents; legal services; freight and shipping charges; data-processing supplies; office supplies; postage; copy supplies; non-capitalized equipment purchases; dues and memberships; registration fees; capital lease principal payments; and, capital lease interest payments. The operations vendor contracted payments mentioned above may include both the base contracted amounts and any additional amounts from contract amendments that are necessary to request computer programming changes to implement requirements from special bills passed by the Colorado General Assembly. The Department uses contract amendments on an annual basis to provide additional pools of funding for computer programming changes that will enhance and update the functionality of CBMS to meet Medicaid requirements better.

The Governor's Office of Information Technology (OIT) currently has oversight of daily operations for the vendor, Deloitte Consulting. However, both DHS and HCPF have CBMS funding appropriated to them because the two departments can claim federal funding from their federal government partners that, in turn, increases the total amount of funding available to OIT as reappropriated funding to cover CBMS expenditures. HB 12-1339 funding for CBMS Modernization was included in this particular CBMS line item for CBMS during the FY 2011-12 from which a roll forward request was approved. Again in FY 2012-13 additional CBMS funding for CBMS Modernization funding was included in this line item through the Supplemental Bill, SB 13-089. However, beginning with the FY 2013-14 Long Bill, SB 13-230, a new line item called CBMS Modernization Project was created. A detailed discussion of the CBMS Modernization Project is provided under that line item name.

COLORADO BENEFITS MANAGEMENT SYSTEM, HCPF-ONLY

The Department submitted S-12, BA-5 "CBMS Technical Adjustment for Fund Splits and HCPF Only Projects" in its January 3, 2012 budget submission, which was approved by passage of the Supplemental Bill HB 12-1184 to create this line item. The initial appropriation to this line contained CBMS funding for HB 09-1293 (Hospital Provider Fee) related projects, but the line item can be used for CBMS projects funded from other sources if the projects are intended for the benefit of Medicaid and the Department, without benefit to DHS. Authorization for this line item can be inferred from 25.5-4-106, C.R.S. and 25.5-4-204, C.R.S.

CBMS SAS-70 AUDIT

Funding for this line item began in FY 2005-06 for the State Auditor's Office to complete an audit based on the Statement on Auditing Standards 70 (SAS-70), which was recommended by Joint Budget Committee (JBC) staff. There is no specific authorization for the

line item in statute; however, authorization can be inferred from 26-1-112, C.R.S. SAS-70 applies to all service organizations, not just to the contractor for CBMS.

This type of audit is generally completed once per year, and the annual appropriations are renewed each year. When this line item originally began, these annual appropriations were paid by the Department and DHS to the Colorado Office of State Auditor, which, in turn, contracted with an independent auditor to conduct an audit staffed by control-oriented professionals who have experience in accounting, auditing, and information security. Such an audit allows the service organization to have its control policies and procedures evaluated and tested by an independent party. This audit also allows the user organization to be assured that the service organization is fulfilling its security requirements. During FY 2011-12 and FY 2012-13, Deloitte Consulting has completed the SAS-70 Audit itself.

CBMS MODERNIZATION PROJECT PERSONAL SERVICES, OPERATING EXPENSES, AND CENTRALLY APPROPRIATED EXPENSES

This line item was new to the Department in the FY 2014-15 Long Bill, HB 14-1336, although the line had existed previously in the Department of Human Services' (DHS) Long Bill in the section related to Colorado Benefits Management System (CBMS) funding. The funding is used to cover training for county departments of social services on how to use CBMS and how to adjust county practices and procedures when computer programming changes are made by the vendor for CBMS.

Funding for training purposes related to CBMS originally started with the passage of HB 12-1339, resulting in CBMS Modernization. From FY 2011-12 through FY 2013-14, the funding was reflected only in DHS' Long Bill, although the Department has historically used the funding, so the change was made to reflect the funding at the Department during FY 2014-15 and going forward.

CBMS MODERNIZATION PROJECT, PHASE II

The CBMS Modernization Project was initially funded via HB 12-1339, "Concerning the Colorado Benefits Management System improvement and Modernization Project." The bill was a response to the Department's budget request, S-14, "CBMS Improvements in FY 2011-12 and FY 2013-14," submitted February 10, 2012, jointly by the Department, the Department of Human Services, and the Governor's Office of Information Technology. Although CBMS was implemented in September 2004, the project began development in 1996, and some of the technology used dated back to the 1996 timeframe. Consequently, the operation of CBMS was inefficient and outdated by 2012. There was a great need to update both the hardware and the software for CBMS. Over the years, new laws at both the federal and the State levels put additional strains on the capacity of CBMS to respond quickly to the changing needs of Colorado clients. The plan was to begin work during FY 2011-12 to consider the updating processes during FY 2012-13 and to complete the updates during FY 2013-14.

The federal Patient Protection and Affordable Care Act (often abbreviated as ACA) created the need for many changes in federal regulations related to eligibility for the Medicaid program. Those changes have caused many additional updates to be made to CBMS. By the end of FY 2013-14, the much needed changes were not entirely finished. Therefore, the modernization project continues under a new line item name of CBMS Modernization Project, Phase II.

Phase II of the CBMS Modernization Project was first funded by the FY 2014-15 Long Bill, HB 14-1336, to continue the updates that began in the first phase from FY 2011-12 through FY 2013-14. The overall approach is to move to more modern supporting software, including moving to storage on the Cloud. Specific projects to respond to revised ACA regulations continue to be funded through the appropriation for tis line item. One such project is an interface with the Colorado Health Exchange, called Connect for Health Colorado, through which Colorado residents can sign up online for health insurance as required by the Affordable Care Act.

OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS

The "Other Office of Information Technology Services" line item includes Medicaid funding for expenses associated with the DHS Information Systems but specifically excludes CBMS and CBMS SAS-70 funding. The Office of Information Technology is responsible for developing and maintaining the major DHS centralized computer systems, including systems that link to all counties in the State. Not all of these systems support Medicaid functions, and, therefore, not all receive Medicaid funding. The Office supports centralized databases and provides support and training to users, including county staff and private social services providers. The Office of Information Technology Services also helps set policies and strategic directions for de-centralized information technology systems that are operated by individual divisions within DHS.

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING

The Department of Human Services' (DHS) Office of Operations appropriation contains funding for four divisions: Facilities Management, Accounting, Procurement, and Contract Management, of which some are partially funded with Medicaid funding. This appropriation is for the cost of salaries and operating expenses associated with some of the positions in this Office, as well as for utilities costs and Common Policy items such as Vehicle Lease Payments. POTS funding is centrally appropriated in the Executive Director's Office for these positions and is transferred into the Office of Operations as the fiscal year progresses.

(D) DIVISION OF CHILD WELFARE – MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located under the Deputy Executive Director of the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for

and protecting their children. Although the Division of Child Welfare Administration was created as a separate line item in the budget for DHS in FY 2000-01, the separate line for the Department titled "(D) Division of Child Welfare: Administration" was added to the Department's budget in FY 2005-06. Prior to that fiscal year, both administration and services were in a blended appropriation titled "Division of Child Welfare – Medicaid Funding." The child welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of social services, but other types of services are provided under federal Title IV-E funding. The federal Centers for Medicare and Medicaid Services requires that Title XIX and Title IV-E funding be separated.

Staff who oversee the child welfare program for Title IV-E funding are also responsible for oversight of the county work to enroll the children for Medicaid services. The Medicaid funding in this administration line item pays for the portion of the staff salaries related to Medicaid-oversight work.

CHILD WELFARE SERVICES

The Child Welfare Services line item supports funding for counties to administer child welfare programs and deliver associated services for children and families. The line item provides funding for: (1) county administration for child welfare services; (2) out-of-home placement, including foster care; (3) out-of-home placement in residential-care facilities for children needing behavioral-health treatment; (4) regular adoptions; (5) subsidized adoptions; (6) child welfare-related child care and burials; (7) administration of the Interstate Compact on Placement of Children who are moving in or out of Colorado, including placement of children by Colorado in another state; and, (8) other necessary and appropriate services for children and families. These services comprise Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside their homes for their own protection or for community safety.

(E) OFFICE OF EARLY CHILDHOOD – MEDICAID FUNDING

During the 2013 Legislative Session, the General Assembly passed HB 13-1117 "Concerning Alignment of Child Development Programs." The legislation was signed into law by the Governor on May 7, 2013. One result was the creation of the Office of Early Childhood at the Department of Human Services. The early childhood system in Colorado includes four system sectors that address the needs of children, including early learning, child health, child mental health, and family support and parent education. Research confirms that these areas, along with prenatal health, are interrelated and that it is difficult if not impossible to separates children's emotional, behavioral, and learning needs from their prenatal and child health and wellness or from the involvement and support of their families.

DIVISION OF COMMUNITY AND FAMILY SUPPORT, EARLY INTERVENTION SERVICES

Early Intervention Services Case Management previously existed at DHS under Services for People with Disabilities as Community Services for People with Developmental Disabilities. The case management of these services is aimed at families who have infants and toddlers through age two, with developmental disabilities that have been identified at a young age. Therefore, HB 13-1117 has repositioned this service under the Office of Early Childhood to improve the delivery of services to very young children.

(F) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees.

Previously, the Department's share of the funding for SAVE was included in the Department's Medical Services Premiums line item, and costs related to Medical Assistance Sites checking immigration status for clients presenting for medical care at those sites are still charged to Medical Services Premiums.

(G) BEHAVIORAL HEALTH SERVICES – MEDICAID FUNDING

COMMUNITY BEHAVIORAL HEALTH ADMINISTRATION

This line item funds the Medicaid portion of Personal Services and Operating Expenditures for oversight of the mental health services provided by the Department of Human Services (DHS). Colorado provides mental health care to a larger population than just Medicaid clients, but this line item is prorated from the total state expenditures for mental health care to represent only the Medicaid portion. There is no specific statutory reference for Mental Health Administration, but a reference may be inferred from 24-1-120, C.R.S.

Personal Services for the staff in this administrative line item include salaries and associated expenditures. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

MENTAL HEALTH TREATMENT SERVICES FOR YOUTH

HB 99-1116 created the Child Mental Health Treatment Act to improve the probability that children with significant mental health needs receive treatment. This legislation was passed to help mitigate parents' difficulty in navigating the various governmental systems including child welfare, mental health, law enforcement, juvenile justice, education, and youth corrections in seeking help for their children. Often these situations resulted from a court action of dependency and neglect that caused parents to give up custody of their children to the local departments of human/social services. The Child Mental Health Treatment Act set up a framework for getting mental health treatment for these children without resorting to the dependency and neglect action. However, during the evaluation process for admission to the residential treatment center, if it is determined that the child is a victim of child abuse, the case is referred to child welfare services.

HIGH-RISK PREGNANT WOMEN PROGRAM

This line item provides Medicaid funding for prenatal and postpartum substance abuse treatment services for women at risk of a poor birth outcome due to alcohol or substance abuse. The High-Risk Pregnant Women Program, also called "Special Connections," is a state-wide voluntary alcohol and drug treatment program for pregnant women who are at risk of poor birth outcomes due to substance abuse-related disorders. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in DHS.

MENTAL HEALTH INSTITUTES

The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 in Denver, and the Colorado Mental Health Institute, established in 1879 in Pueblo. The institutes provide inpatient psychiatric hospital services to citizens of Colorado having a major illness such that the individual cannot be expected to function and/or be treated in the community. Both locked and unlocked treatment units are provided, with a wide variety of assessment and treatment services offered to patients. Services have included: individual, group, and family therapy; treatment goal-setting; work therapy; community-readiness skills; medication and health education; education programs; pastoral services; substance abuse education and treatment; and, discharge and aftercare planning. The Fort Logan location does not have an inpatient treatment program for substance abuse.

Funding for the institutes comes from a variety of sources such as disability payments, Medicare, Medicaid, third-party insurers or insurance companies, counties, school districts, and other State Departments (such as the Department of Corrections or the Department of Education). These institutes also transfer a portion of their revenues to other offices in DHS that provide support for operations of the institutes. Such supporting operations include facilities management and accounting functions in the Office of Operations and computer functions in the Office of Information Technology. The Department pays for the services provided to Medicaid clients at the institutes as well as the Medicaid portion of the functions in the Office of Operations and Office of Information Technology that relate to Medicaid services at the institutes.

(H) SERVICES FOR PEOPLE WITH DISABILITIES – MEDICAID FUNDING

REGIONAL CENTERS

The State operates three regional centers that provide direct support for adults with developmental disabilities. These are individuals who have significant needs and for whom adequate services and support are not available in the Community-Centered Board (CCB) system to safely meet their needs. The regional centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional centers serve adults in community group homes that provide services for between four and eight people. The majority of regional center beds are operated under the same comprehensive Home- and Community-Based waiver program that supports most community-based residential services. The regional center campuses also house Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID).

The Department provides funding for Personal Services, Operating Expenses, capital outlay for patient needs, leased space, residential incentive allowance, and the purchase of services. Funding has recently been allocated through the budget process to address staffing, wait-lists, and Medicaid waiver changes.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with regional centers of the Department of Human Services (DHS). The line item was added through the FY 2003-04 Supplemental Bill (HB 04-1320) to reflect historic department practice.

(I) ADULT ASSISTANCE PROGRAMS, COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING

This line item was created to support funding of the State Ombudsman program of the Department of Human Services (DHS), which manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. This program provides liaison services between DHS and its clients who are being served by the Division of Aging and Adult Services. The programs provided for the elderly are administered through the county departments of human/social services or through regional Area Agencies on Aging. This program also provides statewide advocacy for residents in long-term care facilities. The advocate can investigate complaints made by or on behalf of residents in the long-term care facilities.

The types of services provided under this program include a nutrition program, a caregiver program, a senior employment program, the long-term care ombudsman program mentioned above, and other supportive services. Because Medicaid pays for services in long-term care facilities to clients who are categorically eligible for Medicaid, the possibility exists that clients in those facilities may need someone

to intervene on their behalf when the need arises. Therefore, Medicaid pays a small contribution to the overall costs of the State Ombudsman Program.

(J) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

The Division of Youth Corrections is under the direction of the Deputy Executive Director for Children, Youth, and Families at the Department of Human Services (DHS). The Division of Youth Corrections provides management and oversight to state-operated and private-contract residential facilities, as well as community-based alternative programs, that serve youth between 10 and 20 years of age who: have demonstrated delinquent behavior; are detained while awaiting adjudication; or are committed to the Division of Youth Corrections after adjudication. Facilities for youth offenders include intensive secure units, medium care units, staff secure units, and non-secure community residential programs. Only residents in non-secure, community residential programs would qualify for Medicaid. Other youths in secured, locked facilities have their medical care paid entirely through State General Fund.

The Division is currently organized into Administration, Institutional Programs, and Community Programs; Medicaid funding is provided only within the Community Programs section. Within the Community Programs section, the Medicaid funding covers a portion of Personal Services, a portion of Purchase of Contract Placements (mental health services), and a portion for a Managed Care Pilot Project.

(K) OTHER

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS

This line item was created in the FY 2009-10 Long Bill (SB 09-259). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, including common costs, overhead costs, or joint costs.

II. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2014 that affects Department policies and procedures.

HB 14-1045 (Primavera, Aguilar, Crowder) Breast and Cervical Cancer Program
The bill extends the Breast and Cervical Cancer Prevention and Treatment Program (BCCP) in the Department through July 1, 2019. In addition, the bill makes several changes related to the funding of BCCP including allowing moneys in the BCCP fund to pay for BCCP coverage regardless of where a woman with breast or cervical cancer was diagnosed.

HB 14-1211 (Young, Tochtrop) Ensuring Access to Complex Rehabilitation Medicaid
The bill requires the Department to recognize complex rehabilitation technology (CRT) as a unique category of services under Medicaid. CRT is defined in the bill as manual wheelchair systems, alternate positioning systems, standing frames, gait trainers, and other specifically designed options and accessories classified as durable medical equipment (DME). The bill sets requirements for HCPF related to CRT being recognized as a benefit category.

HB 14-1213 (Kraft, Tharp, Crowder) Pharmacy Benefit Manager Requirements
The bill places new requirements on pharmacy benefit managers (PBMs) including giving pharmacies the right to obtain, within 10 days of the request, the sources used to determine maximum allowable cost pricing in each contract between a PBM and pharmacy, updating pricing information at least every seven days, and maintaining procedures to eliminate products from the lists of drugs subject to maximum allowable costs pricing.

HB 14-1357 (Young, Aguilar) In-home Support Services in Medicaid Program
The bill makes several changes to in-home support services (IHSS) provided by the Department under various Medicaid Home- and Community-Based Services (HCBS) waiver programs. These changes include allowing IHSS to be provided in the home or in the community and adding spouses as an eligible family member who may act as an attendant providing IHSS to a HCBS waiver client.

HB 14-1358 (Young, Joshi, Aguilar) Sunset Review In-home Support Services
This bill implements the 2013 sunset recommendations for the In-home support services (IHSS) program administered by the Department. Changes under the bill include extending IHSS under certain Medicaid Home- and Community-Based Services (HCBS) waiver programs through September 1, 2019, and adding clients served through the Spinal Cord Injury Waiver Pilot Program as eligible for IHSS.

HB 14-1360 (Young, Aguilar) Sunset Review Licensure of Home Care Agencies
The bill continues the regulation of home care agencies and home care placement agencies until September 1, 2019, and implements the recommendations contained in the Department of Regulatory Agencies' sunset report, as modified by the House Public Health Care and Human Services Committee.

HB 14-1368 (May, Gerou, Hodge) Transfer Youth Dev Disab to Adult Services
The bill, recommended by the Joint Budget Committee (JBC), establishes a plan and appropriates funds to transfer youths who are 18 to 20 years of age and who have intellectual and developmental disabilities (IDD) and receive services though county child welfare services, which are funded through the Department of Human Services (DHS) into adult services for persons with IDD under Medicaid Home- and Community-Based Services (HCBS) in the Department.

SB 14-130 (Tochtrop, Primavera) Increase Personal Care Allowance Nursing Facility
The bill increases the per month basic minimum amount that state licensed nursing facilities and intermediate care facilities allow a long-term care resident as a personal needs allowance (PNA).

SB 14-144 (Aguilar, Nicholson, Ginal) Family Medicine Residency Programs In Rural Areas
The bill makes changes to the Commission on Family Medicine (commission) related to family medicine residency programs in rural and underserved areas.

SB 14-151 (Tochtrop, Young) Nursing Home Innovations
The bill modifies how revenue from fines levied on nursing facilities used to provide nursing home innovation grants may be used and makes numerous changes to the Nursing Home Innovation Grant Program.

SB 14-159 (Aguilar, Primavera) Implement Med Clean Claims Recommendations
The bill modifies the deadlines for developing and implementing the standard payment rules and claim edits and adds a year-long public review period to test the long-term governance process for the rules and edits.

SB 14-180 (Kefalas, Swalm) Transfer Senior Dental Program to Department of Health Care Policy and Financing
The bill transfers the Dental Assistance Program for Seniors, also known as the Old Age Pension Dental Program, from the Department of Public Health and Environment (DPHE) to the Department as of July 1, 2015.

SB 14-215 (Steadman, Duran, Gerou) Disposition of Legal Marijuana Related Revenue
The bill creates the Marijuana Tax Cash Fund (MTCF) for tax revenue collected in connection with the retail marijuana industry and identifies the purpose for which moneys may be appropriated from the MTCF.

III. HOT ISSUES

1. DELIVERY SYSTEM DESIGN

Over the past year, the Department has invested a significant amount of effort and resources to modernize the delivery system design for Medicaid clients in Colorado. The Department is committed to moving from paying for services to paying for improved outcomes and performance. The Department's goal for an Integrated Delivery System includes continued development of the Accountable Care Collaborative (ACC) as the platform for delivery system reform in Colorado. The ACC drives cost reductions through care coordination, increased primary care capacity, streamlining care delivered to members eligible for both Medicare and Medicaid, and improving delivery of maternal and child health care.

By integrating health care delivery systems, it is possible to improve health outcomes and contain costs through coordinated, member-centric programs that deliver care in a more streamlined, connected manner. Likewise, designing more effective benefits and programs enhances value by ensuring members receive cost-effective, clinically appropriate benefits that emphasize prevention and wellness. Costs are further controlled by shifting payment systems from outdated "pay and chase" models that drive *volume* of services to new systems that pay for *value* and improved health outcomes. These efforts include further development of the ACC and design and implementation plans of the State Innovation Model (SIM) and Innovation Acceleration Plan (IAP). Each of these items is described in this section.

ACCOUNTABLE CARE COLLABORATIVE (ACC) UPDATE

The Accountable Care Collaborative (ACC) is designed to transform the Colorado Medicaid program into an integrated system that increases access to appropriate health care for all its members, improves the long-term health of Colorado Medicaid clients and shifts the Medicaid program to one that focuses on value, not volume. As enrollment continues to grow, the program has a tremendous opportunity to be a driver of changes to the health care delivery system more broadly. The ACC program currently includes over 700,000 Medicaid clients, statewide, and approximately 430 participating Primary Care Medical Providers (PCMPs), which includes over 2,600 rendering practitioners.

The ACC program was designed to be adaptable and to encourage innovation. ACC policy and initiatives foster improvement across the spectrum of health care delivery and target specific areas that have real potential to transform the delivery system and enhance the value of health care in Colorado. Such initiatives include:

ENHANCING PRIMARY CARE

A new incentive will reward PCMPs that meet five out of nine standards for a high-quality, patient-centered medical home. These standards were drawn from those defined by the National Committee for Quality Assurance (NCQA) and adapted to meet the needs of the ACC. As providers stay open on nights and weekends, provide on-site access to behavioral health care providers, collect and regularly update a behavioral health screening (including substance use) for adults and adolescents, and track the status of referrals to specialty care providers, the care for all patients will be improved. Also, this greater access to care and a patient-centered, comprehensive approach will enrich the primary care provider-patient relationship. As these relationships strengthen, individuals will be more likely to seek care from a trusted primary care provider and less likely to rely upon emergency rooms and even specialists.

CONNECTING MEDICAL RESOURCES

Concurrent with strengthening the foundation of the provision of primary care, the ACC is beginning to look at creating medical neighborhoods. A medical neighborhood is a tightly connected, yet flexible, local system with seamless transitions between primary care, specialist care, hospital care, and self-management at home. It is care coordination at its most sophisticated. To support this transition, the Regional Care Collaborative Organizations (RCCOs) developed and provided medical neighborhood/referral protocols that are designed to enhance this work. These protocols are in the initial phases of implementation, and external stakeholders are providing ongoing feedback on their design.

CREATING ACCESS THROUGH TECHNOLOGY

Even with focused development of medical neighborhoods, there is an acute shortage of specialty providers in the State, particularly in rural and frontier areas. The Department is developing a Project ECHO program. Project ECHO is a model that links front-line primary care clinicians with specialist care teams at university medical centers to manage patients who have chronic conditions requiring complex care. With this model, primary care clinicians develop expertise in specific areas, which enables individuals in remote and medically underserved communities to get care they could not easily get before, if at all. The Department believes Project ECHO will foster collaboration between PCMPs and specialists, build expertise among primary care team members, improve the health of clients with chronic conditions, and address prescription drug abuse. This year, there will be a Project ECHO program for pain management, with more Project ECHO Programs to follow beginning in 2015.

CHANGING PATTERNS OF EMERGENCY ROOM UTILIZATION

One key area of focus for the ACC is decreasing inappropriate emergency room (ER) usage. Unnecessary visits to the ER are expensive and are an inefficient way to treat most health care needs. In addition, every unnecessary ER visit potentially channels resources away from more vital and necessary services. Reducing emergency room utilization is a topic that is being addressed nationally, but thus far with mixed results. A number of factors make it difficult to affect the use of the emergency room, including the increase in emergency

rooms and departments, more aggressive advertising by hospitals promoting the use of their emergency room, and a co-pay structure that sometimes makes the emergency room a cheaper option for Medicaid clients.

Over the next fiscal year, the ACC will continue to address ER utilization through these initiatives:

- ER notification to the RCCOs will make it easier for care coordinators and PCMPs to immediately reach out to members and help them avoid further trips to the ER.
- Referral Protocols are being implemented by each RCCO to give structure to medical neighborhoods, facilitating timely and appropriate access to specialty care.
- An enhanced PCMP program that stresses, among other things, afterhours care will help incentivize more providers to have extended hours for appointments.
- Increased emphasis on attributing members to a PCMP, with financial penalties for the RCCOs, will build more medical home relationships for more ACC clients, leading to consistent preventive care and better overall health for ACC members.

ER notification can be a tool used by all payers to support enrollees in using the ER appropriately. As stated above, supporting primary care providers in becoming medical homes, giving them additional training and support through programs like Project ECHO will also have an impact across the delivery system.

PAYING FOR PERFORMANCE OVER VOLUME

Since its inception, the ACC has employed a pay-for-performance program as part of its reimbursement strategy. This program pays RCCOs and PCMPs for consistently meeting quality targets within their region, as measured by Key Performance Indicators (KPI). KPIs measure quality indicators in the areas of ER usage, well-checks for children ages 3-9, and postpartum care for new mothers. In addition, the ACC makes financial incentives available for increasing adolescent physical and behavioral health screenings, increasing the number of primary care office visits by members who have a diagnosed chronic condition, and ensuring that individuals who have been discharged from the hospital visit a doctor for follow-up care within 30 days of their discharge.

MOVING TOWARD WELLNESS

In the coming year, RCCOs across the State will work more closely with public health to help members and communities embrace wellness. They will collaborate on projects that give communities better access to healthy foods and increase opportunities for physical activity. They will also look for ways to connect with community hospitals who have completed Community Health Needs Assessments.

ACC REPROCUREMENT

From the start, the ACC program is meant to be iterative; it was designed with the understanding that delivery system reform takes time and will require continual evolution. The upcoming request for proposals (RFP) process will re-procure the RCCOs that administer the program on a regional basis.

The RFP will be the basis of the next iteration of the ACC. The RFP will lay out the structural vision for the program, and it will contain specific contract requirements for regional entities to follow in the future.

The approach of the re-procurement has been to identify and build upon successes of the first iteration of the program, while making bold improvements in terms of behavioral health integration, alignment with social services, and new payment reforms.

The re-procurement is focused on three core commitments:

- Transforming systems from a medical model to a health model
- Moving toward person-centered, integrated and coordinated supports and services
- Leveraging efficiencies to provide better quality care at lower costs to more people

In December 2013, the Department began developing the materials necessary for the RFP. Early on, the Department also committed to consistent engagement with the stakeholder community. With the help of the Colorado Health Institute, the Department has held 12 public stakeholder meetings. These meetings, which started in early April, have taken place in all seven of the State's regions. Additionally, an ACC Request for Information (RFI), released in fall 2014 and open for public response, will help the Department to structure the specifics of many RFP requirements.

The Department is also committed to closer integration between physical health and behavioral health in the next RFP. Integrated care is more effective, efficient, and is capable of addressing co-occurring behavioral health and physical health needs. More coordination is needed both at the system level and at the provider level. The next RFP will support practices in moving towards being integrated clinics. The RFP will also include provisions related to improved data sharing between care coordinators, providers, and other entities so as to improve the quality of client care.

ACC FULL-BENEFIT MEDICARE-MEDICAID (FBMME) PROJECT UPDATE

Colorado is among a small group of states (15) that have partnered with the Centers for Medicare and Medicaid Services (CMS) to improve and integrate care for Full-Benefit Medicare-Medicaid Enrollees (FBMME). In September 2014, Colorado became the 4th state to begin enrolling FBMME into an improved system of care that will coordinate physical, behavioral, and social health needs.

Colorado's plan will advance the Department's commitment to improving the care and health outcomes for FBMME enrollees. It builds on the infrastructure and resources of the Accountable Care Collaborative (ACC), a central part of Colorado's Medicaid health care delivery system. Colorado's plan is unique because it allows clients to keep their doctors and existing network of providers. Other states are implementing the demonstration in a managed care setting, which in some cases may require a client to change providers.

The goals of the program are congruent with wider department initiatives, including the Triple Aim:

- Improved health outcomes for full benefit Medicare-Medicaid enrollees.
- Improved enrollee experience through enhanced coordination and quality of care.
- Decreased unnecessary and duplicative services, and the resulting costs.

In order to address these goals, the Department seeks to provide greater integration between the ACC program, other Medicaid programs serving the enrollees, and the Medicare program. It is also working to improve transitions of care into and out of Long-Term Services and Supports (LTSS). Additionally, the Department will make it easier for enrollees to understand their benefits and navigate the systems of care.

HOW DOES THE PROGRAM WORK?

The Department has identified several key strategies that will help meet the goals of the program. These include: the Service Coordination Plan (SCP), cross-provider communication agreements, disability competent care and a beneficiary's rights and protections alliance.

WHAT IS HAPPENING NOW?

Monthly enrollment will continue until March 2015. The Department is developing an evaluation plan that will utilize rapid cycle feedback to make improvements to the program. The Department is continuing to work with the Advisory Subcommittee and stakeholders to monitor and improve the program.

ACC PAYMENT REFORM PILOT PROGRAM (HB 12-1281) UPDATE

In FY 2014–15, the ACC is launching a payment reform pilot that has been in the planning stages during the past year. Rocky Mountain Health Plans (RMHP), one Regional Care Collaborative Organization (RCCO), is testing a full-risk capitation model with a subset of its members in seven counties in western Colorado. Instead of receiving per-member per-month (PMPM) administrative payments,

RMHP will receive one payment to cover all physical health care delivered to those members. The payment amounts will differ depending on the age, sex, and eligibility type of the member.

RMHP will pay their primary care medical providers (PCMPs) sub-capitation payments, and, at the end of each pilot year, will share savings with their PCMPs and the local community mental health centers (CMHCs). RMHP has included additional payments to PCMPs in advanced practices for the employment of behavioral health providers on comprehensive care teams. The Department will use this pilot to learn more about how to use payment strategies to better integrate care throughout the State.

As of October 1, 2014, approximately 16,200 clients have been enrolled in the pilot program. RMHP and the Department have developed a phased enrollment approach, starting with specific counties, and will eventually enroll approximately 30,000 clients into all seven target counties.

STATE INNOVATION MODEL (SIM)

Under the leadership of the Governor's Office, the Colorado State Innovation Model (SIM) proposal presents a plan to improve the health of all Coloradans by 2019. To achieve this goal, the State seeks to transform the health care delivery system through the integration of primary care, behavioral health, and public health services. Establishing a strong and ongoing partnership between these three service delivery systems is crucial because health outcomes are strongly impacted by factors beyond the clinical setting, including social, economic, and environmental influences. Key components of the plan include practice transformation support, assistance with transitioning practices to outcomes based payment models, establishment of a statewide data hub, engagement of stakeholders, and a plan to monitor and evaluate all activities.

ACTIVITIES TO DATE

Senior leaders from the Department have partnered with the Governor's Office, CDPHE, CDHS, the Colorado Health Institute, University of Colorado School of Medicine, and the Center for Improving Value in Health Care to create the vision and plan for the SIM proposal. The proposal was formally submitted by the Governor's office to the CMS Innovation Center on July 18, 2014 and is currently under consideration. Department leaders remain involved in responding to CMS questions and in planning for a positive response from CMS, including creating workgroups to further activities in key project areas. According to CMS, awards will be announced in early November 2014.

SHARED APPLICATION AND ELIGIBILITY PROCESS

The Single Eligibility System (SES) is a system that will determine eligibility for Medical Assistance (MA), Advanced Premium Tax Credit (APTC), and Cost Sharing Reduction (CSR). CBMS will determine eligibility for Medical Assistance and, in situations where the client is not eligible, the eligibility information will be used to determine APTC and CSR eligibility. The SES is not a system that

is seen by users. The SES is an eligibility system that runs "behind the scenes" when the PEAK User applies for Medical Assistance only.

The following are features of the SES:

ACCOUNT ACCESS
- Applicants and clients will be able to add and designate individuals or agencies to their application to act on their behalf.

SINGLE SIGN-ON
- A single sign-on functionality will allow applicants and clients to login to their account using their PEAK or Connect for Health Colorado login credentials.
- Applicants and clients will be able to use their Connect for Health Colorado login to sign in to PEAK to check the status of their submitted Medical Assistance application.

SINGLE, SHARED APPLICATION
- Applicants and clients will be able to apply for Medical Assistance benefits with one application process and be determined for Medicaid, Child Health Plan Plus (CHP+) or financial assistance to purchase private insurance through the Connect for Health Colorado marketplace. This means applicants will only need to complete one set of questions.
- Applicants will also receive joint letters regarding what program they may qualify.

REAL-TIME ELIGIBILITY DECISIONS
- Real-time eligibility decisions will continue. Over 70% of applications entered into PEAK are currently determined with real-time eligibility.
- Applicants who complete their online application for Medical Assistance completely and accurately may find out immediately if they qualify for Medicaid or CHP+. Those who do not qualify for Medicaid or CHP+ can apply at Connect for Health Colorado and learn right away if they qualify for a tax credit or cost-sharing reduction to help lower their health care costs.

2. COMMUNITY LIVING ADVISORY GROUP (CLAG) RECOMMENDATIONS

In July 2012, Governor Hickenlooper created the Office of Community Living through an Executive Order, codified by HB 13-1314, with the goal of redesigning all aspects of the long-term services and supports (LTSS) delivery system, including service models, payment structures, and data systems to create efficient and person-centered, community-based care. In furtherance of this goal, the

Executive Order also created the Community Living Advisory Group (CLAG) to consider and recommend necessary changes to the system to ensure responsiveness, flexibility, accountability, and self-directed LTSS.

The Advisory Group began its work during August 2012 by reviewing prior advisory work that had been done in the LTSS arena, including the work of the SB 05-173 Advisory Committee, the HB 07-1374 Working Group, and the 2010 Olmstead Work Group. It worked with the Colorado Commission on Aging and other planning groups to complete its work and build on previous discussions and recommendations. The Department engaged professional facilitation and planning expertise to ensure that the Advisory Group succeeded in developing and presenting a plan for LTSS system redesign in the time designated by the Governor.

As the Advisory Group did its work, subcommittees and ad hoc work groups were added as needed. Each of these subcommittees were co-chaired by a community stakeholder and a state staff. The Department thanks the Departments of Human Services, Public Health and Environment, and Regulatory Agencies for providing subcommittee co-chairs as needed. The Advisory Group created the following subcommittees during the course of its work:

- Care Coordination
- Consumer Direction
- Entry Point/Eligibility
- Regulatory
- Waiver Simplification
- Workforce

The Department also added Advisory Group members during the two-year work process, when members needed to move off the Advisory Group. The Advisory Group Membership List, at the time it completed its work, is found on the CLAG website[1].

The Advisory Group delivered its Final Report[2] to the Governor and the Executive Directors of the Departments of Health Care Policy and Financing and Human Services on September 30, 2014. The report began with a declaration of shared principles, including (but not limited to):

- affirming the right of all Coloradans to live in communities of their choice;
- affirming that Colorado's LTSS system should be fundamentally person-centered and built on a foundation of consumer choice, cultural competency, dignity, respect, and freedom; and,

[1] https://www.colorado.gov/pacific/hcpf/community-living-advisory-group
[2] https://www.colorado.gov/pacific/sites/default/files/Community_Living_Advisory_Group_Final_Report_09-30-14.pdf

- affirming that all parties in Colorado's LTSS system share a responsibility to use public dollars wisely – Coloradans who receive LTSS, the entities that offer and administer those services, and the entities that provide them.

The CLAG Final Report includes the following areas of recommendation:

- Improve the Coordination and Quality of Care in the LTSS System
- Streamline and Simplify Access to LTSS
- Simplify the State's HCBS Waivers
- Grow and Strengthen the Paid and Unpaid LTSS Workforce
- Harmonize and Simplify LTSS Regulations
- Promote Accessible, Affordable, and Integrated Housing
- Promote Employment Opportunities for All
- Support Implementation (of the recommendations)

3. MMIS REPROCUREMENT (COMMIT PROJECT) UPDATE

The COMMIT Project is the name of the Department's initiative to implement a modern Medicaid Management Information System (MMIS), including hardware, software, and business process workflows designed to meet the criteria for a "mechanized claim processing and information retrieval system" required by federal law to participate in the Medicaid program. The MMIS' core function is to adjudicate and process the Department's medical claims and capitations for payment; it also provides other important functions including provider enrollment and management, certain client management functions, and analytics and reporting. Since the MMIS electronically processes approximately 97% of the Department's claims, its capabilities and limitations play a pivotal role in how the Department administers the Medicaid program.

In late 2013, the Department selected a new contractor to design, develop, test and implement a new state of the art MMIS. HP Enterprise Services (HP) was selected to be the Department's new MMIS contractor and fiscal agent. Colorado, in selecting the most current version of HP's *interChange* system, will be the 15th state to implement the *interChange* platform, which has been implemented and federally certified in 13 states over the past decade. Though official operation of the MMIS by HP will not begin until 2016, work has already commenced to ensure the new system will meet the needs of the Department while incorporating the latest technology. HP is the nation's largest provider of Medicaid and Medicare process management services, administering $140 billion in benefits a year. It serves as the fiscal agent or principal IT provider for Medicaid in 19 states, and supports healthcare services throughout 33 states across the country.

Between April and September 2014, the Department conducted a comprehensive evaluation of all current processes. HP worked with the Department to identify gaps in the current processes to incorporate Department requirements into the Colorado *interChange's* new capabilities.

The next major milestone in launching the new Colorado *interChange* began in September 2014 and ends in June 2016. Working closely with HP, the Department will develop, test, and implement a provider enrollment tool that includes a modernized provider enrollment and reenrollment processes. The new provider enrollment process will help the Department implement the new federally mandated electronic provider screening for providers with legal or regulatory actions. During this stage, HP will coordinate outreach and support efforts for providers during the provider reenrollment process. HP will also partner with the Department to update the current provider manuals to reflect the new processes and procedures.

The final stage of the rollout of the new MMIS begins in October 2014 and culminates in October 2016. During this stage, HP and the Department will design, develop, test, and implement the new MMIS. This stage will also include training for internal and external stakeholders on the new system, capabilities, and processes. The Colorado *interChange* development and implementation takes approximately 32 months, with the system go-live date of November 2016.

The final step in the new systems' implementation is to obtain system certification from the Centers for Medicare and Medicaid Services (CMS). To be certified by CMS, the new Colorado *interChange* must be operational for one year. The Department and HP expect to gain certification of the system in late 2017. HP will then serve as the Department's Fiscal Agent for claims process, provider enrollment, and other operations related to the Colorado *interChange*. Ongoing maintenance will be necessary to ensure the system is up-to-date. The Department is poised to work closely with HP to ensure the system meets the changing needs of the Department in the years to come.

The Department released three (3) separate Requests for Proposals (RFPs) as part of the overall COMMIT Project to provide flexibility for Offerors to provide innovative solutions. HP is building the MMIS, and the two remaining RFPs are:

- **Pharmacy Benefits Management System (PBMS)**
  - PBMS Support and Operations
  - Point-of-Sale Pharmacy Billing Services
  - Pharmacy Call Center Services
  - Prospective Drug Utilization Review (Pro-DUR)
  - Drug Rebate Administrative Management System (DRAMS)
  - Maintenance of Preferred Drug List (PDL) and Pharmacy Reference Files

- **Business Intelligence and Data Management Services (BIDM)**
  - Decision Support system (DSS)
  - Business Intelligence Services
  - Data Warehouse
  - Statewide Data and Analytics Contractor (SDAC) Services

4. NEW HOME- AND COMMUNITY-BASED SERVICES (HCBS) REGULATIONS

In January 2014, the federal Centers for Medicare and Medicaid Services (CMS) promulgated a final federal rule (CMS-2249-F and CMS 2296-F) to ensure that individuals receiving long-term services and supports (LTSS) through home- and community-based services (HCBS) programs under 1915(c) and 1915(i) have full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal finances, and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

Each state operating a Section 1915 (c) waiver or a Section 1915 (i) state plan benefit that was in effect on or before March 17, 2014, must file a Statewide Transition Plan to describe how the state will bring all pre-existing 1915(c) or 1915(i) programs into full compliance with the home and community based services (HCBS) settings requirements in 42 CFR § 441.301(4)(5) and 441.710(a)(1)(2). The Statewide Transition Plan must delineate how the State will bring all 1915(c) and 1915(i) programs in that state into alignment with the regulation requirements. States are allowed a maximum of five years to make the transition. Stakeholders were asked to provide public input and comment in order to allow Colorado to develop a comprehensive transition plan.

CONFLICT-FREE CASE MANAGEMENT

Department staff are working to align direct services delivery and case management with the new federal rules, the specifics of which are found at 42 CFR § 441.301(c)(1)(vi). The new rules bar the delivery of services by the same business entity that provides case management services. Community Centered Boards (CCBs) are the agencies contracted by the Department to provide case management services for individuals receiving services through the Home- and Community-Based Services waivers serving people with intellectual and developmental disabilities. The CCBs also deliver services, which makes the current model out of compliance with the new federal regulations.

To address this issue, the Department convened a task group of stakeholders to explore options for the delivery of conflict-free case management. This group was charged to develop recommendations for consideration by the Department regarding models for conflict-free case management for clients enrolled in each of the three waivers for persons with intellectual and/or developmental disabilities:

- Home- and Community-Based Services (HCBS) waiver for Persons with a Developmental Disability (HCBS-DD);
- HCBS-Supported Living Services (HCBS-SLS) waiver; and
- HCBS-Children's Extensive Support (HCBS-CES) waiver.

The task group began meeting in February 2014. Under the guidance of an outside consultant, Segue Consulting, the group researched other states' models and analyzed those models in the context of the new rules. Based on the work of the task group, Segue Consulting will deliver a report with recommendations to the Department. Upon receipt of the report, the Department will seek public comment from stakeholders, providers, clients, and families regarding the recommendations. Final responses from to the public comment will be provided by the Department in December 2014.

The task group will provide final recommendations to the Department based on public comment and in alignment with the recommendations in the report of the Community Living Advisory Group (CLAG), created by Executive Order 2012-027 by Governor Hickenlooper.

THE DEPARTMENT'S APPROACH TO TRANSITION

The Department's approach in creating the Statewide Transition Plan and to engage stakeholders in the process is based on Colorado's core values to help individuals access care at the right time and right place and improve Colorado's ability to work effectively within and across systems to ensure person-centered care and full community engagement.

The Department developed a Statewide Transition Plan pursuant to 42 CFR § 441.301(c)(6) that contains the actions that Colorado will take to bring all waivers into compliance with requirements set forth in 42 CFR § 441.301(c)(4-5). The Department submitted the Statewide Transition Plan to CMS in October 2014.

5. PERSON-CENTERED PLANNING

Person-centered planning is an evidence-based approach to service planning for people in need of services and supports. The approach balances the medical and behavioral supports needed to keep a person healthy and in the community with the individual preferences and quality of life concerns that support individuals to lead independent, self-determined lives in a way that upholds a person's dignity, values, or preferences. Person-centered service planning requirements are woven into the federal home- and community-based services final rules effective March 17, 2014, with which the Department must be in compliance by 2018.

The Centers for Medicaid and Medicare Services (CMS) specifies that service planning for participants in Medicaid home- and community-based services options under section 1915(c) and 1915(i) of the Social Security Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process be directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance. The Department is currently working with stakeholders, clients, providers, and other interested parties regarding the implementation of person-centered planning.

Staff within the Department's Division for Intellectual and Developmental Disabilities, Office of Community Living, are, in addition to making progress towards compliance with the federal rule, working to imbue person-centered principles into all levels of service delivery. These efforts touch the work of direct service providers up through program administrators and office-level management at the Department. To effect this change, and ensure person-centered thinking is a part of staff decision making, all staff within the Office of Community Living attend a two-day person-centered thinking training hosted by area Community Centered Boards (CCBs). Case managers and direct service providers also attend the trainings and leadership meetings at several CCBs throughout the State that are working to become certified person-centered organizations.

Department staff, including key managers, attend "Coaches and Leaders" meetings at CCBs throughout the State that include providers, case managers, and executive-level leadership to effect this culture change. The meetings allow for open discussion of successes and challenges faced by providers and case managers and allow for dialogue with leadership on the formulation of solutions and policy changes that can help advance person-centeredness.

6. COLORADO'S COMMUNITY LIVING (OLMSTEAD DECISION) PLAN

On June 22, 1999, the United States Supreme Court found in *Olmstead v. L.C.* that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination based on disability. Referring to the *Americans with Disabilities Act* (ADA), the *Olmstead* decision holds states accountable for providing community-based care whenever appropriate, rather than placing individuals with disabilities in institutional settings.

The *Olmstead* decision was reinforced on June 18, 2001, when President George W. Bush signed an Executive Order requiring states to provide community-based alternatives for individuals with disabilities in compliance with the terms of the *Olmstead* decision. Many states have drafted strategic plans as either a direct result of litigation or to comply with the Olmstead Decision. In Colorado, the Departments of Health Care Policy and Financing, Human Services, and Local Affairs, along with support and input from a host of community organizations and persons living with disabilities, have collaborated on compliance with the *Olmstead* decision.

On July 30, 2014, Colorado officially released its strategic Olmstead plan, "*Colorado's Community Living Plan*[3]," which was signed by Executive Directors: Sue Birch (HCPF), Reggie Bicha (DHS), and Reeves Brown (DOLA). With this plan, Colorado is articulating its commitment to foster community living for individuals with disabilities. Colorado's intent with this plan is out of respect for the rights of individuals at risk for placement in long-term care facilities to know about their community-based alternatives and to support them in action upon their choices about how, when and where they receive the supports they need.

7. HOSPITAL QUALITY INCENTIVE PAYMENT (HQIP) PROGRAM

The Hospital Quality Incentive Payment (HQIP) program is part of the Hospital Provider Fee model, providing up to 7% of the funds collected annually from the Hospital Provider Fee toward incenting hospitals to improve health care outcomes for their patients. The total funds available for incentive payment in FY 2014-15 is nearly $61.5 million.

The four goals of the HQIP program are:

- Improve care
- Adhere to Value Based Purchasing principles as established by the Colorado Hospital Association (CHA)
- Maximize participation in the Medicaid program
- Maximize the number of hospitals eligible to fully participate

  Incentive payments are based on two factors: 1) hospital metrics, and 2) Medicaid volume. Hospital metrics are selected by a subcommittee of the Hospital Provider Fee Oversight and Advisory Board, comprised of hospital representatives, CHA staff members, and Department staff members. The subcommittee monitors the quality of care provided to hospitalized Coloradans using these metrics. The number of persons with Medicaid coverage cared for at a hospital is the other part of the payment equation.

The metrics used for payment change over time in order to strengthen the incentive process and improve outcomes. As performance reaches an optimum level for a given metric, the metric is moved to a "maintenance mode" where performance rates are monitored to

[3] https://www.colorado.gov/pacific/sites/default/files/Colorado%20Community%20Living%20Plan-July%202014.pdf

assure optimum performance is maintained. Performance on maintenance metrics are not included in the metrics used to determine incentive payments.

Health care providers can improve outcomes by planning and executing changes in procedures or behavior. In order to maximize quality outcomes, the Department notifies hospitals of the base and optional metrics as soon as possible before the performance period, providing time for planning, executing and improving. Achieving good performance rates can make a difference in the incentive payments as evidenced by the payments made to these four hospitals:

Hospital	Medicaid Volume	Percentage of Possible Points Earned	Incentive Payment Amount
A	Mid-range	78%	$3,192,407
B	Mid-range	41%	$1,176,820
C	Low	78%	$310,678
D	Low	41%	$152,357

Hospitals vary in level of performance on each metric. This variation is addressed by assigning points to various levels of performance, high points given to desired rates and lower or no points assigned to undesired rates. In the example above, hospitals A and B had very similar Medicaid volume but the number of points "earned" for the quality metrics varied considerably. This variation resulted in a $2.0 million difference in incentive payment. A similar situation occurred for hospitals C and D, with a payment difference of approximately $150,000. This type of payment structure reinforces the message that good performance rates on selected measures can result in increased incentive payments.

There were 87 hospitals eligible for participation in the HQIP program for FY 2014-15. Some of the long-term care and specialty hospitals had no Medicaid volume for the year, leaving 75 hospitals eligible for participation. The Medicaid discharges in these 75 hospitals ranged from 1 to 6,184. The quality points earned ranged from 33% to 100%. Quality points are adjusted for hospitals not eligible for a metric (e.g. obstetrics not a service at the hospital). Incentive payments ranged from $4,265 to over $5.0 million.

The subcommittee is introducing base and optional metrics next year, to increase the number of hospitals eligible to fully participate. Base metrics are the metrics all hospitals can report if applicable to the services they provide. Optional metrics can be used by hospitals who do not provide a service reflected in the base measures (e.g., obstetrics).

Base metrics used for payment in FY 2015-16:

- Emergency Room Process Measure
- Elective Deliveries between 37 and 39 Weeks
- Cesarean Section Rate
- 30-Day All-Cause Readmissions
- Hospital Consumer Assessment of Healthcare Providers and Systems

Optional metrics for FY 2015-16:

- Culture of Safety Measure
- Active Participation in Regional Collaborative Care Organizations
- Advanced Care Planning
- Tobacco Screening

IV. WORKLOAD REPORTS

The Department collects data from various sources that provide information on consumer satisfaction, the number of clients served, as well as demographics. This information is provided below.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) [4] is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans. The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client satisfaction surveys to ascertain whether clients are satisfied with their care, as well as to ascertain differences among clients enrolled in Medicaid managed care, the Primary Care Physician Program (PCPP), and Medicaid fee-for-service (FFS). As part of a comprehensive quality improvement effort, the Department requires managed physical health plans to conduct the CAHPS 5.0H Survey of Adults and 5.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2013. The survey period for this questionnaire was July through December 2013, and the data was collected between February and May 2014. National averages for 2013 (the most recent comparative data available) are included.

Starting in 2013 the Department developed a customized CAHPS questionnaire in order to better measure the consumer satisfaction of the Regional Collaborative Care Organizations (RCCO). This questionnaire added questions from the CAHPS Patient Centered Medical Home supplement and also eliminated the section in the standard CAHPS questionnaire regarding the rating of the consumers Health Plan. As FFS is not a Health Plan per se this section was determined to be of little use and perceived to create confusion with the consumer. The CAHPS scores have been broken down by RCCO (of which there are seven). Due to some early problems with methodologies the Colorado Medicaid FFS category includes both RCCO and non-RCCO members. That issue has since been resolved and starting with next year's survey there will be a distinct category of non-RCCO FFS reported. The two Managed Care plans, Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans (RMHP) did not use the Departments modified questionnaire but did include several additional questions from the modified version.

[4] CAHPS is a registered trademark of the Agency for Health Care Research and Quality.

★★★★★90th Percentile or Above ★★★★75th-89th Percentiles ★★★50th-74th Percentiles
★★25th-49th Percentiles ★Below 25th Percentile – Of National Average

Adult Medicaid

Table 1-2
NCQA Comparisons Highlights

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate
Colorado Medicaid FFS	★	★	★	★★★	★★★	★★
Colorado RCCO Program	★	★★	★	★	★	★★★
Region 1. Rocky Mountain Health Plans	★	★★	★+	★★	★	★★★★
Region 2. Colorado Access	★★	★★	★+	★★+	★+	★★★★+
Region 3: Colorado Access	★	★★★	★+	★	★	★★★
Region 4. Integrated Community Health Partners	★	★	★+	★	★★★	★★
Region 5. Colorado Access	★★	★★★★★	★+	★★	★★★	★★★★★
Region 6: Colorado Community Health Alliance	★★	★	★+	★	★	★★★
Region 7: Community Care of Central Colorado	★	★	★+	★★★	★	★
Colorado Medicaid PCPP	★★	★★	★	★★	★★	★★★

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results

Adult Medicaid

Table 1-6 NCQA Comparisons Highlights		
Colorado Medicaid Aggregate	**DHMC**	**RMHP**
★ Customer Service	★ Customer Service	★+ Customer Service
★ Getting Care Quickly	★ Getting Care Quickly	★★ Rating of Specialist Seen Most Often
★ Getting Needed Care	★ Getting Needed Care	★★★ Getting Care Quickly
★ Rating of Specialist Seen Most Often	★ Rating of All Health Care	★★★ Rating of All Health Care
★★ Rating of All Health Care	★ Rating of Health Plan	★★★★ Getting Needed Care
★★ Rating of Health Plan	★ Rating of Specialist Seen Most Often	★★★★ How Well Doctors Communicate
★★★★ How Well Doctors Communicate	★★★★ How Well Doctors Communicate	★★★★ Rating of Health Plan
★★★★ Rating of Personal Doctor	★★★★ Rating of Personal Doctor	★★★★ Rating of Personal Doctor
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

Child Medicaid

Table 1-2 NCQA Comparisons Highlights						
Plan Name	**Rating of All Health Care**	**Rating of Personal Doctor**	**Rating of Specialist Seen Most Often**	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**
Colorado Medicaid FFS	★★	★★	★★+	★	★★	★★★
Colorado RCCO Program	★	★★	★★	★	★★	★★
Region 1: Rocky Mountain Health Plans	★★	★	★★+	★	★★	★
Region 2: Colorado Access	★★★★	★★★★	★★★★★+	★★+	★★	★★
Region 3: Colorado Access	★	★	★★+	★★	★	★★★
Region 4: Integrated Community Health Partners	★	★	★+	★★★+	★	★★
Region 5: Colorado Access	★★	★★★	★★★★+	★	★	★
Region 6: Colorado Community Health Alliance	★★★	★★	★★★+	★+	★★	★★
Region 7: Community Care of Central Colorado	★	★	★+	★	★★	★
Colorado Medicaid PCPP	★★★★	★★★★	★★+	★★★★	★★★★★	★★★
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.						

Child Medicaid

Table 1-5 NCQA Comparisons Highlights		
Colorado Medicaid	**DHMC**	**RMHP**
★ Customer Service	★ Customer Service	★+ Customer Service
★ Getting Needed Care	★ Getting Care Quickly	★★ Rating of All Health Care
★★ Getting Care Quickly	★ Getting Needed Care	★★★ Getting Care Quickly
★★★ How Well Doctors Communicate	★★ How Well Doctors Communicate	★★★ How Well Doctors Communicate
★★★ Rating of All Health Care	★★★ Rating of All Health Care	★★★ Rating of Health Plan
★★★ Rating of Health Plan	★★★ Rating of Health Plan	★★★ Rating of Personal Doctor
★★★★ Rating of Personal Doctor	★★★★ Rating of Personal Doctor	★★★★+ Rating of Specialist Seen Most Often
★★★★★ Rating of Specialist Seen Most Often	★★★★★+ Rating of Specialist Seen Most Often	★★★★ Getting Needed Care
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

HEALTH EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)[5] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

The Department requires Medicaid health plans to report HEDIS measure rates each year. The Department uses this information to track the health plans' performance in providing care and services to Medicaid clients and to identify and prioritize improvement efforts. As part of a comprehensive quality initiative, the Department required health plans to report rates on HEDIS measures for adults and children. The data presented in the following tables shows performance rates on measures ranging from child immunization rates to antibiotic utilization. The 2014 rates reflect services provided January 1, 2013, through December 31, 2013.

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Childhood Immunization Status (H)						
Combination 2	77.70%	78.35%	68.13%	78.13%	69.21%	61.20%
Combination 3	73.95%	78.10%	65.45%	76.70%	66.67%	58.33%
Combination 4	66.23%	77.62%	59.85%	73.77%	61.36%	50.16%
Combination 5	60.71%	62.04%	52.55%	61.59%	53.53%	43.75%
Combination 6	51.66%	63.50%	42.34%	59.50%	44.19%	37.11%
Combination 7	57.17%	62.04%	48.42%	60.40%	49.71%	37.89%
Combination 8	48.12%	63.26%	38.44%	58.15%	40.57%	34.00%
Combination 9	43.93%	53.53%	35.28%	50.29%	36.90%	29.00%
Combination 10	41.94%	53.53%	32.12%	49.61%	34.01%	26.52%
4 Diptheria, Tetanus, Pertussis	81.02%	79.08%	72.26%	79.73%	73.07%	67.41%
3 Polio Virus immunizations	94.70%	90.27%	88.08%	91.77%	88.48%	82.85%
1 Measles, Mumps, and Rubella	91.61%	90.02%	86.62%	90.56%	87.04%	82.29%
3 Haemophilus Influenza Type b	89.62%	90.02%	87.59%	89.89%	87.84%	83.47%
3 Hepatitis B immunizations	93.82%	91.00%	88.32%	91.95%	88.71%	81.60%
1 VZV (Chicken Pox) vaccine	91.39%	89.78%	86.62%	90.32%	87.02%	82.28%
4 Pneumococcal Conjugate	79.91%	83.21%	74.21%	82.10%	75.06%	68.96%
1 Hepatitis A	74.17%	88.56%	76.40%	83.70%	77.19%	68.34%

[5] HEDIS is a registered trademark of the National Committee for Quality Assurance.

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Required Number of Rotavirus	73.51%	65.94%	65.69%	68.49%	66.00%	57.29%
2 Influenza	57.84%	71.53%	51.09%	66.91%	52.80%	46.93%
Immunizations for Adolescents (H)						
Combination 1	59.65%	83.21%	63.75%	76.13%	65.20%	58.11%
Meningococcal	59.87%	83.70%	64.48%	76.54%	65.89%	59.63%
Tdap/Td	88.25%	86.37%	82.24%	86.94%	82.79%	76.34%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H)						
0 visits	0.36%	2.68%	2.92%	1.94%	2.85%	1.88%
6 or more	80.73%	63.50%	61.56%	68.97%	62.11%	62.19%
Percent of Children with Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (H)	66.01%	62.04%	60.34%	63.35%	60.69%	61.13%
Percent of Adolescents Receiving a Well-Care Visit (H)	45.58%	49.88%	36.50%	48.50%	37.79%	38.79%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)						
BMI Assessment - 3-11 Years	82.37%	91.84%	50.00%	88.51%	54.27%	57.87%
Nutrition Counseling - 3-11 Years	67.31%	81.56%	54.03%	76.54%	56.52%	60.58%
Physical Activity Counseling - 3-11 Yrs	63.78%	61.70%	46.98%	62.43%	48.69%	46.95%
BMI Assessment - 12-17 Years	77.44%	91.47%	49.56%	86.65%	53.61%	56.05%
Nutrition Counseling - 12-17 Years	53.38%	74.42%	46.02%	67.18%	48.33%	53.46%
Physical Activity Counseling - 12-17 Yr	59.40%	70.54%	48.67%	66.71%	50.64%	56.82%
BMI Assessment - Total	80.90%	91.73%	49.88%	87.94%	54.08%	57.24%
Nutrition Counseling - Total	63.15%	79.32%	51.82%	73.66%	54.23%	58.20%
Physical Activity Counseling - Total	62.47%	64.48%	47.45%	63.78%	49.25%	50.28%
Testing for Children with Pharyngitis	90.86%	70.06%	71.46%	85.51%	72.61%	74.23%
Prenatal and Postpartum Care (H)						
Timeliness of Prenatal Care	95.64%[3]	89.29%	72.75%	92.06%	74.60%	79.82%
Postpartum Care	73.83%[3]	57.42%	56.93%	64.57%	57.67%	57.63%
Percent of Children and Adolescents' Accessing Primary Care Practitioner						
Ages 12 to 24 Months	97.85%	92.24%	95.38%	93.99%	95.23%	94.61%
Ages 25 Months to 6 Years	86.29%	74.69%	81.77%	78.52%	81.40%	81.91%
Ages 7 to 11 Years	89.55%	80.82%	86.00%	83.32%	85.68%	86.37%
Ages 12 to 19 Years	87.88%	82.32%	85.66%	84.07%	85.48%	86.30%
Percent of Adults Accessing Preventive Care						
Total	88.33%	71.00%	76.37%	76.83%	76.42%	77.23%
Ages 20 to 44 Years	85.35%	66.60%	74.55%	73.55%	74.46%	75.84%
Ages 45 to 64 Years	91.90%	76.54%	81.19%	80.95%	81.17%	81.60%

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Ages 65 Years and Older	95.53%	75.00%	75.70%	81.19%	76.15%	75.93%
Percent of Women Receiving Chlamydia Screening						
Total	45.32%	68.49%	50.77%	59.43%	51.66%	54.02%
Ages 16 to 20 Years	42.67%	68.34%	46.10%	58.76%	47.45%	49.39%
Ages 21 to 24 Years	47.76%	68.64%	55.12%	60.12%	55.61%	58.33%
Percent of Women Receiving Breast Cancer Screening	51.96%	54.59%	28.51%	53.73%	31.17%	30.42%
Percent of Women Receiving Cervical Cancer Screening (H)	70.25%	67.15%	56.45%	68.28%	57.67%	44.91%
Percent of Adults Receiving BMI Assessment (H)	85.81%	90.51%	69.10%	88.73%	71.34%	72.82%
Anti-depressant Medication Management						
Effective Acute Phase Treatment	NB	41.58%	63.25%	41.58%	62.03%	63.73%
Effective Continuation Phase Treatment	NB	30.43%	47.69%	30.43%	46.72%	48.82%
Adherence to Antipsychotics for Individuals with Schizophrenia	NB	64.02%	71.83%	64.02%	70.37%	75.85%^
Follow-up Care for Children Prescribed ADHD Medication						
Initiation	31.67%	14.81%	35.05%	23.68%	34.18%	39.47%
Continuation	35.90%	NA	36.97%	30.16%	36.51%	43.63%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment						
Initiation	NB	45.39%	28.69%	45.39%	30.19%	29.62%
Engagement	NB	3.50%	6.12%	3.50%	5.88%	5.60%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	NB	89.67%	87.50%	89.67%	87.78%	—
Diabetes Monitoring for People With Diabetes and Schizophrenia	NR	70.97%	29.66%	70.97%	33.11%	—
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NR	NA	21.28%	NA	21.57%	—
Controlling High Blood Pressure (H)	73.38%[3]	66.42%	47.93%	68.56%	50.48%	44.85%
Comprehensive Diabetes Care (H)						
HbA1c Testing	89.37%	88.81%	72.75%	88.98%	74.56%	67.43%
HbA1c Poor Control (>9.0%)	26.41%	31.87%	59.61%	30.21%	56.33%	62.68%
HbA1c Control (<8.0%)	65.61%	58.39%	34.31%	60.60%	37.24%	32.00%
Eye Exam	63.62%	49.64%	40.15%	53.90%	41.68%	42.80%
LDL-C Screening	72.09%	76.64%	59.85%	75.26%	61.57%	55.81%
LDL-C Level <100 mg/dL	43.19%	55.23%	26.28%	51.56%	29.10%	27.07%
Medical Attention for Nephropathy	75.58%	82.48%	70.07%	80.38%	71.22%	70.21%
Blood Pressure Controlled <140/80 mm Hg	55.15%	56.20%	38.69%	55.88%	40.61%	39.55%

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Blood Pressure Controlled <140/90 mm Hg	76.74%	72.99%	56.20%	74.14%	58.21%	54.09%
Percent of Clients on Persistent Medications Receiving Annual Monitoring						
Total	83.22%	84.74%	83.07%	84.40%	83.29%	80.28%
ACE Inhibitors or ARBs	85.86%	87.30%	85.61%	87.02%	85.84%	86.55%
Digoxin	70.45%	67.41%	66.18%	68.50%	66.51%	54.32%
Anticonvulsants	NA	NA	89.77%	NA	89.16%	86.85%
Diuretics	86.67%	86.05%	86.28%	86.18%	86.26%	86.19%
Use of Imaging Studies for Low Back Pain	74.15%	81.12%	78.46%	78.49%	78.46%	—
Pharmacotherapy Management of COPD Exacerbation						
Systemic corticosteroid	32.53%	64.90%	61.30%	55.67%	59.43%	—
Bronchodilator	48.19%	76.92%	79.79%	68.73%	76.11%	—
Use of Appropriate Medications for People with Asthma						
Total	85.94%	78.61%	86.63%	80.79%	86.07%	—
5-11 years	95.74%	89.82%	92.45%	91.56%	92.38%	—
12-18 years	84.34%	84.52%	85.85%	84.45%	85.72%	—
19-50 years	71.43%	64.05%	78.06%	66.20%	76.85%	—
51-64 years	NA	60.87%	80.06%	67.06%	77.52%	—
Asthma Medication Ratio						
Total	62.35%	53.60%	66.56%	56.22%	65.55%	60.16%
5-11 years	77.42%	71.62%	78.38%	73.33%	77.96%	68.77%
12-18 years	57.83%	53.25%	63.66%	54.85%	62.82%	60.22%
19-50 years	42.86%	34.21%	49.81%	36.74%	48.47%	45.81%
51-64 years	NA	39.13%	58.40%	45.88%	55.96%	51.20%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.59%	30.26%	23.05%	30.03%	23.79%	—
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	52.54%	81.48%	74.10%	69.29%	73.17%	—
Ambulatory Care (Per 1,000 Member Months)						
Outpatient Visits	401.91	225.92	310.19	280.29	307.00	—
ED Visits	58.85	44.05	60.39	48.62	59.14	64.84
Inpatient Utilization - General Hospital/Acute Care						
Discharges per 1,000 MM (Total Inpatient)	9.25	5.53	9.44	6.68	9.15	—
Days per 1,000 MM (Total Inpatient)	32.87	21.84	26.98	25.25	26.80	—
Average Length of Stay (Total Inpatient)	3.55	3.95	2.86	3.78	2.93	—

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Discharges per 1,000 MM (Medicine)	4.08	4.27	3.9	4.21	3.93	—
Days per 1,000 MM (Medicine)	16.74	14.41	12.6	15.13	12.87	—
Average Length of Stay (Medicine)	4.10	3.37	3.23	3.59	3.27	—
Discharges per 1,000 MM (Surgery)	1.73	1.17	1.82	1.34	1.77	—
Days per 1,000 MM (Surgery)	8.86	7.21	9.26	7.72	9.10	—
Average Length of Stay (Surgery)	5.13	6.15	5.09	5.75	5.14	—
Discharges per 1,000 MM (Maternity)	6.14	0.15	6.49	2.02	6.02	—
Days per 1,000 MM (Maternity)	12.94	0.40	8.94	4.31	8.46	—
Average Length of Stay (Maternity)	2.11	2.61	1.38	2.13	1.40	—
Antibiotic Utilization						
Average Scrips for PMPY for Antibiotics (All Ages)	1.01	0.35	0.99	0.55	0.94	—
Averages Days Supplied per Antibiotic Scrip (All Ages)	9.71	9.54	9.74	9.63	9.73	—
Average Scrips PMPY for Antibiotics of Concern (All Ages)	0.36	0.10	0.37	0.18	0.35	—
Percentage of Antibiotics of Concern of all Antibiotic Scrips (All Ages)	35.93%	27.65%	37.69%	32.24%	37.32%	—
Frequency of Selected Procedures (Per 1,000 Member Months)						
Bariatric weight loss surgery (0-19 Male)	0.00	0.00	0.00	0.00	0.00	0.00
Bariatric weight loss surgery (0-19 Female)	0.00	0.00	<0.014	0.00	<0.01	0.00
Bariatric weight loss surgery (20-44 Male)	0.07	0.00	0.02	0.02	0.02	0.03
Bariatric weight loss surgery (20-44 Female)	0.23	0.05	0.09	0.12	0.09	0.09
Bariatric weight loss surgery (45-64 Male)	0.00	0.00	0.02	0.00	0.02	0.01
Bariatric weight loss surgery (45-64 Female)	0.53	0.03	0.12	0.19	0.13	0.11
Tonsillectomy (0-9 Male & Female)	1.31	0.36	0.58	0.65	0.59	0.62
Tonsillectomy (10-19 Male & Female)	0.92	0.19	0.38	0.40	0.39	0.47
Hysterectomy, Abdominal (15-44 Female)	0.29	0.06	0.1	0.14	0.10	0.21
Hysterectomy, Abdominal (45-64 Female)	0.13	0.12	0.19	0.13	0.18	0.33
Hysterectomy, Vaginal (15-44 Female)	0.60	0.09	0.18	0.27	0.19	0.29
Hysterectomy, Vaginal (45-64 Female)	0.20	0.15	0.17	0.17	0.17	0.26
Cholecystectomy, Open (30-64 Male)	0.05	0.05	0.03	0.05	0.03	0.07
Cholecystectomy, Open (15-44 Female)	0.00	0.05	0.01	0.03	0.02	0.02
Cholecystectomy, Open (45-64 Female)	0.07	0.06	0.06	0.06	0.06	0.07
Cholecystectomy(laparoscopic) (30-64 Male)	0.94	0.20	0.28	0.39	0.29	0.36
Cholecystectomy(laparoscopic) (15-44 Female)	1.35	0.55	0.83	0.83	0.83	0.92
Cholecystectomy(laparoscopic) (45-64 Female)	1.60	0.36	0.73	0.75	0.74	0.72
Back Surgery (20-44 Male)	0.63	0.06	0.32	0.22	0.31	0.37

HEDIS 2014 Medicaid Measures	RMHP	DHMC	FFS	HMO Weighted Average[1]	Colorado Medicaid Weighted Average[2]	HEDIS 2013 National Medicaid Average
Back Surgery (20-44 Female)	0.23	0.04	0.21	0.11	0.20	0.23
Back Surgery (45-64 Male)	0.95	0.09	0.52	0.29	0.50	0.78
Back Surgery (45-64 Female)	0.73	0.15	0.67	0.33	0.63	0.81
Mastectomy (15-44 Female)	0.04	0.02	0.04	0.03	0.04	0.03
Mastectomy (45-64 Female)	0.07	0.03	0.37	0.04	0.34	0.30
Lumpectomy (15-44 Female)	0.30	0.09	0.1	0.16	0.10	0.10
Lumpectomy (45-64 Female)	0.53	0.27	0.58	0.35	0.56	0.47

[1] HMO Weighted Averages were derived from the rates of RMHP and DHMC.
[2] Colorado Medicaid Weighted Averages were derived from the rates of RMHP, DHMC, and FFS.
[3] The plan chose to rotate this measure for HEDIS 2014 reporting.
[4] While the audited rate was 0.00, there was at least one procedure reported for this procedure.
— This measure was required for FFS only. Therefore, HMO Weighted Averages were not calculated.
NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.
NB indicates that the health plan did not offer the benefit required by the measure.
NR indicates that the rate could not be publicly reported because the calculated rate was materially biased, or the health plan chose not to report the measure, or the health plan was not required to report the measure.
^ RMHP and DHMC were not required to report this measure for HEDIS 2014; the Colorado Medicaid Weighted Average for this measure was derived from the rates of FFS only.

DEMOGRAPHICS AND EXPENDITURES

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department is reporting county-level data from the 2008-2012 American Community Survey conducted by the United States Census Bureau as well as 2014 demographic forecasts from the Colorado Department of Local Affairs (DOLA).

The United States Census Bureau derives its definition of poverty from the Office of Management and Budget's Strategic Policy Directive 14. This definition of poverty accounts for family size, income, and the age of each family member. As the percentage of families living below poverty increases, the demand for medical care provided by the State will increase. Similarly, as the percentage of female-headed households increases, utilization of State provided medical care may increase. Conversely, a higher percent of the population in the labor force should result in a reduction of State provided medical care.

Medicaid

Using the Department's decision support system database, FY 2013-14 Medicaid data was collected for the following statistics and reported in the following table for the State by county:

- Medicaid Clients;
- Medicaid Expenditures; and
- Percentage Share of Medicaid Expenditures.

Please note monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS). The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System – MMIS) than COFRS. In addition, Medicaid expenditures reported include those for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2014 FY 2015-16 Budget Request.

Children's Basic Health Plan

Using FY 2013-14 expenditures and caseload data for the Children's Basic Health Plan (CHP+), the Department compiled the following data and reported it by county in the following table:

- Average Number of Children per Month;

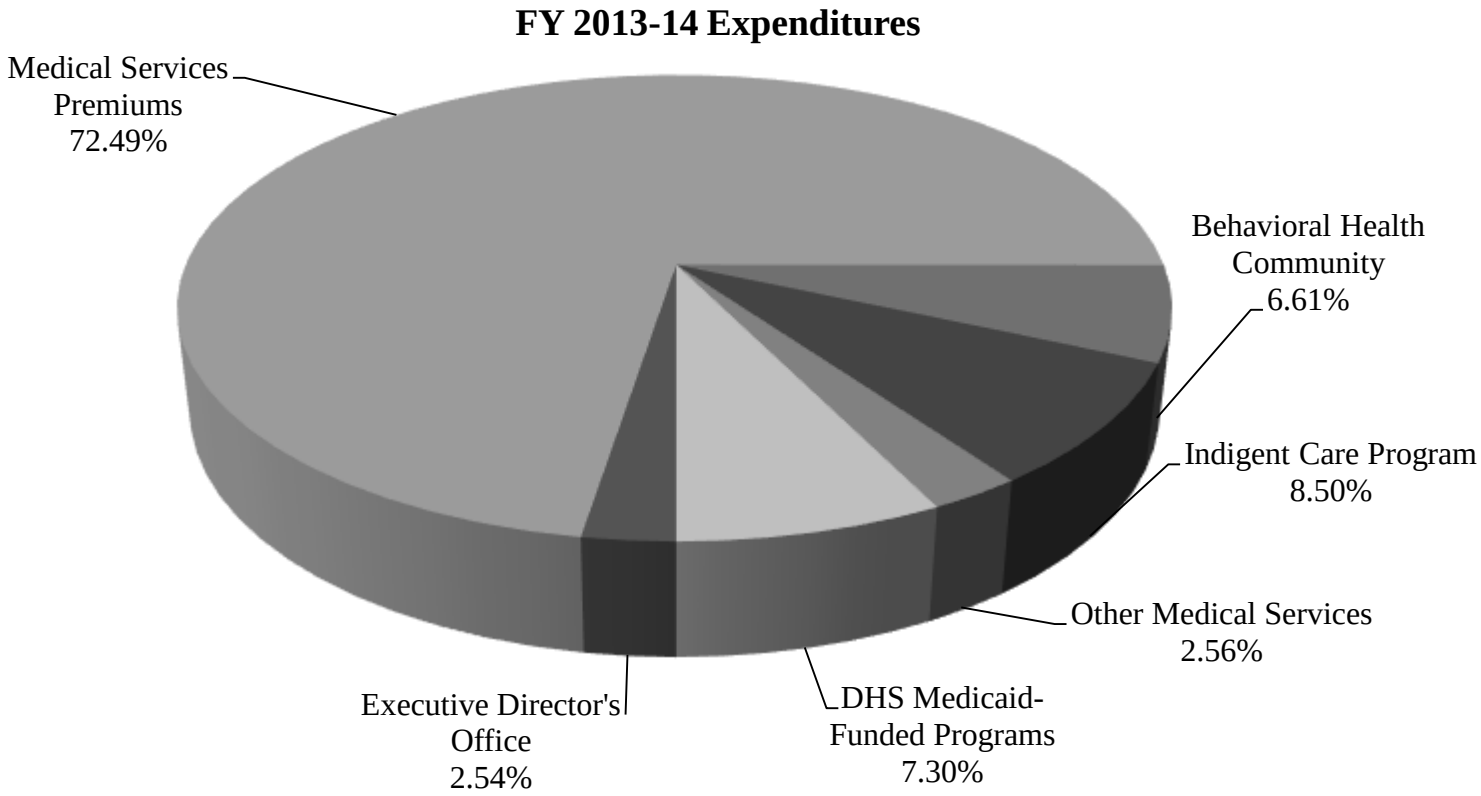
- Percent of Population Enrolled in CHP+; and
- Children's Basic Health Plan Expenditures.

CHP+ provides medical and dental services to children under age 19 and provides prenatal care and delivery for adult pregnant women who are at or below 250% of the federal poverty level. The total CHP+ expenditures presented in the statewide table below include Children's Basic Health Plan Premium Costs and Children's Basic Health Plan Dental Benefit Costs.

Please note all data included in prior Budget Submissions were aggregated at the Health Insurance Portability and Accountability Act (HIPAA) region level. HIPAA requires the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, 20 "HIPAA Regions" were developed for the provision of Department information. However, beginning with the FY 2011-12 Budget Submission, the Department began reporting data at the county level and suppressed data for small counties. For data at the HIPAA-region level, please contact the Department's Budget Division at 303-866-6077.

Colorado's Demographics, Medicaid, CHP+, and CICP – A Statewide View	
Characteristics	**Colorado**
Demographic Characteristics	
Population (2014) [1]	5,363,689
Population (2008-12) [2]	5,042,853
Percent of Population 16+ in Labor Force (2008-12) [2]	69.50%
Percent of Population 5+ Where Non-English is Spoken at Home (2008-12) [2]	16.79%
Percent of Households with Income Below the Poverty Level in Past 12 Months (2008-12) [2]	8.90%
Percent of Female-Headed Households (2008-12) [2]	10.06%
Medicaid Characteristics (FY 2013-14) [3]	
Average Number of Medicaid Clients per Month	763,814
Percent of Population Who are Medicaid Clients	14.24%
Medicaid Expenditures	$4,009,079,140
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]	
Average Number of CHP+ Clients per Month	62,505
Percent of Population Who are CHP+ Clients	1.17%
CHP+ Expenditures	$182,753,054
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)	
Unduplicated Client Count	208,672
Number of CICP Providers [5]	71
CICP Expenditures	$1,429,157,164

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?
3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients
4) CHP+ caseload does not include "CHP+ at Work" clients
5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics



Source: November 1, 2013 FY 2015-16 Budget Request, Schedule 2.

MEDICAID AND THE CHILDREN'S BASIC HEALTH PLAN

The following table provides insight on the variations of Medicaid and the Children's Basic Health Plan (CHP+) usage across Colorado counties. Some important caveats must be mentioned concerning the Medicaid and CHP+ data presented in the county table. Overall, Medicaid and CHP+ expenditure figures by county will not equal the year-to-date FY 2013-14 appropriated or actual amounts. This is due to several factors:

1. The Medicaid expenditure data were pulled from a different source than the rest of the Budget's exhibits to obtain county numbers. However, Medicaid caseload will match the official caseload count as reported in "Exhibit B – Medicaid Caseload Forecast." CHP+ caseload will not match the official caseload count as reported in "Exhibit C.8 – CHIP Federal Allotment Forecast," as data reported here exclude enrollees in the CHP+ at Work program. Expenditures for the CHP+ at Work Program have been excluded from the data reported here.

2. County Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services.

3. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS), whereas the Decision Support System database extracts its data from the Medicaid Management Information System (MMIS). Therefore, total Medicaid and CHP+ expenditures presented in the table below will not reconcile with the numbers for actual medical services reported in the June 2014 Premiums, Caseload, and Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures are not linked to an eligibility type or to a unique client identification number for the following reasons:

    a. These expenditures are financial transaction payments made to individual providers, health maintenance organizations, and service organizations, such as cost settlements or lump sum payments; and

    b. Clients had no recorded eligibility type, gender, and/or county code.

4. Expenditures for drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments are not included in expenditure amounts by region since they are not processed in the MMIS.

5. Data has been suppressed for select counties with smaller populations per the Department's threshold rule to comply with HIPAA regulations.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Adams**	**Alamosa**	**Arapahoe**	**Archuleta**
Demographic Characteristics				
Population (2014) [1]	475,956	16,033	614,068	12,803
Percent of Colorado Population (2014) [1]	8.87%	0.30%	11.45%	0.24%
Population (2008-12) [2]	442,996	15,750	574,357	12,109
Percent of Colorado Population (2008-12) [2]	8.78%	0.31%	11.39%	0.24%
Percent of Population 16+ in Labor Force (2008-12) [2]	71.80%	58.03%	72.08%	61.12%
Percent of Homes Where Non-English is Spoken (2008-12) [2]	28.06%	23.03%	22.43%	9.97%
Percent of Population Living Below the Poverty Level (2008-12) [2]	10.90%	15.00%	9.00%	7.40%
Percent of Female-Headed Households (2008-12) [2]	13.29%	11.40%	12.18%	7.12%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	91,471	4,647	85,871	1,825
Percent of Population Who are Medicaid Clients	19.22%	28.98%	13.98%	14.25%
Medicaid Expenditures	$431,247,878	$24,061,210	$457,452,059	$7,769,697
Percent of Total Medicaid Expenditures	10.76%	0.60%	11.41%	0.19%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	8,316	303	7,530	228
Percent of Population Who are CHP+ Clients	1.75%	1.89%	1.23%	1.78%
CHP+ Expenditures	$24,372,096	$896,086	$22,264,758	$675,794
Percent of Total CHP+ Expenditures	13.34%	0.49%	12.18%	0.37%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	40,731	7,189	1,163	0
Number of CICP Providers [5]	4	2	3	0
CICP Expenditures	$353,125,958	$9,790,384	$9,021,156	$0
Percent of Total CICP Expenditures	24.71%	0.69%	0.63%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Baca**	**Bent**	**Boulder**	**Broomfield**
Demographic Characteristics				
Population (2013) [1]	3,759	6,135	312,715	61,604
Percent of Colorado Population (2013) [1]	0.07%	0.11%	5.83%	1.15%
Population (2007-11) [2]	3,783	6,192	297,218	55,913
Percent of Colorado Population (2007-11) [2]	0.08%	0.12%	5.89%	1.11%
Percent of Population 16+ in Labor Force (2007-11) [2]	60.89%	36.99%	70.30%	74.38%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	5.80%	17.64%	16.13%	12.72%
Percent of Population Living Below the Poverty Level (2007-11) [2]	11.20%	17.60%	6.40%	4.30%
Percent of Female-Headed Households (2007-11) [2]	5.49%	16.77%	7.84%	8.39%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	779	1,249	28,005	3,942
Percent of Population Who are Medicaid Clients	20.73%	20.36%	8.96%	6.40%
Medicaid Expenditures	$6,354,146	$8,499,507	$154,786,787	$25,051,550
Percent of Total Medicaid Expenditures	0.16%	0.21%	3.86%	0.62%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	84	70	2,717	527
Percent of Population Who are CHP+ Clients	2.23%	1.14%	0.87%	0.86%
CHP+ Expenditures	$238,676	$211,435	$7,841,498	$1,518,163
Percent of Total CHP+ Expenditures	0.13%	0.12%	4.29%	0.83%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	208	0	3,601	0
Number of CICP Providers [5]	1	0	2	0
CICP Expenditures	$438,339	$0	$49,113,986	$0
Percent of Total CICP Expenditures	0.03%	0.00%	3.44%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Population (2013) [1]	18,884	1,942	9,045	8,410
Percent of Colorado Population (2013) [1]	0.35%	0.04%	0.17%	0.16%
Population (2007-11) [2]	17,879	2,095	9,059	8,241
Percent of Colorado Population (2007-11) [2]	0.35%	0.04%	0.18%	0.16%
Percent of Population 16+ in Labor Force (2007-11) [2]	57.73%	66.35%	72.53%	57.65%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	6.12%	10.84%	4.79%	34.17%
Percent of Population Living Below the Poverty Level (2007-11) [2]	6.40%	3.90%	5.50%	13.70%
Percent of Female-Headed Households (2007-11) [2]	7.41%	4.66%	3.56%	12.21%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	2,243	271	812	2,511
Percent of Population Who are Medicaid Clients	11.88%	13.95%	8.98%	29.86%
Medicaid Expenditures	$11,502,210	$1,190,496	$3,232,846	$12,017,034
Percent of Total Medicaid Expenditures	0.29%	0.03%	0.08%	0.30%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	294	42	76	250
Percent of Population Who are CHP+ Clients	1.56%	2.16%	0.84%	2.97%
CHP+ Expenditures	$815,250	$127,230	$221,627	$742,617
Percent of Total CHP+ Expenditures	0.45%	0.07%	0.12%	0.41%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	220	0	0	336
Number of CICP Providers [5]	1	0	0	1
CICP Expenditures	$3,670,777	$0	$0	$700,727
Percent of Total CICP Expenditures	0.26%	0.00%	0.00%	0.05%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Population (2013) [1]	3,669	5,448	4,567	31,078
Percent of Colorado Population (2013) [1]	0.07%	0.10%	0.09%	0.58%
Population (2007-11) [2]	3,556	5,747	4,208	30,710
Percent of Colorado Population (2007-11) [2]	0.07%	0.11%	0.08%	0.61%
Percent of Population 16+ in Labor Force (2007-11) [2]	51.90%	36.26%	52.68%	55.81%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	50.51%	15.35%	3.67%	10.76%
Percent of Population Living Below the Poverty Level (2007-11) [2]	18.40%	17.40%	8.40%	11.50%
Percent of Female-Headed Households (2007-11) [2]	11.57%	9.53%	2.78%	8.32%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	1,187	999	493	5,587
Percent of Population Who are Medicaid Clients	32.36%	18.34%	10.79%	17.98%
Medicaid Expenditures	$5,716,136	$5,194,007	$1,440,568	$23,657,322
Percent of Total Medicaid Expenditures	0.14%	0.13%	0.04%	0.59%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	54	41	51	454
Percent of Population Who are CHP+ Clients	1.47%	0.75%	1.12%	1.46%
CHP+ Expenditures	$163,322	$124,683	$157,499	$1,332,938
Percent of Total CHP+ Expenditures	0.09%	0.07%	0.09%	0.73%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	0	65	483
Number of CICP Providers [5]	0	0	1	1
CICP Expenditures	$0	$0	$21,536	$1,973,467
Percent of Total CICP Expenditures	0.00%	0.00%	0.00%	0.14%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Population (2013) [1]	664,293	2,077	308,810	55,579
Percent of Colorado Population (2013) [1]	12.38%	0.04%	5.76%	1.04%
Population (2007-11) [2]	604,356	1,806	286,883	51,850
Percent of Colorado Population (2007-11) [2]	11.98%	0.04%	5.69%	1.03%
Percent of Population 16+ in Labor Force (2007-11) [2]	71.28%	59.34%	75.72%	82.71%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	27.32%	1.16%	8.97%	30.63%
Percent of Population Living Below the Poverty Level (2007-11) [2]	14.20%	8.80%	2.80%	6.90%
Percent of Female-Headed Households (2007-11) [2]	10.27%	6.44%	7.23%	7.35%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	124,466	299	12,814	4,132
Percent of Population Who are Medicaid Clients	18.74%	14.40%	4.15%	7.43%
Medicaid Expenditures	$638,274,860	$1,193,470	$72,902,379	$12,937,993
Percent of Total Medicaid Expenditures	15.92%	0.03%	1.82%	0.32%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	7,800	40	1,773	600
Percent of Population Who are CHP+ Clients	1.17%	1.93%	0.57%	1.08%
CHP+ Expenditures	$22,700,984	$108,303	$5,105,957	$1,692,252
Percent of Total CHP+ Expenditures	12.42%	0.06%	2.79%	0.93%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	33,274	563	0	0
Number of CICP Providers [5]	4	1	0	0
CICP Expenditures	$284,209,902	$126,677	$0	$0
Percent of Total CICP Expenditures	19.89%	0.01%	0.00%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Population (2013) [1]	24,821	665,277	48,443	60,612
Percent of Colorado Population (2013) [1]	0.46%	12.40%	0.90%	1.13%
Population (2007-11) [2]	23,058	622,816	47,006	56,330
Percent of Colorado Population (2007-11) [2]	0.46%	12.35%	0.93%	1.12%
Percent of Population 16+ in Labor Force (2007-11) [2]	71.18%	69.26%	39.35%	73.97%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	5.24%	11.32%	11.57%	24.72%
Percent of Population Living Below the Poverty Level (2007-11) [2]	3.60%	9.10%	11.70%	7.70%
Percent of Female-Headed Households (2007-11) [2]	5.09%	11.23%	8.82%	8.99%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	1,718	95,466	8,226	8,583
Percent of Population Who are Medicaid Clients	6.92%	14.35%	16.98%	14.16%
Medicaid Expenditures	$8,183,051	$489,604,262	$50,889,301	$42,703,181
Percent of Total Medicaid Expenditures	0.20%	12.21%	1.27%	1.07%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	176	6,122	465	1,103
Percent of Population Who are CHP+ Clients	0.71%	0.92%	0.96%	1.82%
CHP+ Expenditures	$492,534	$17,463,146	$1,331,535	$3,173,328
Percent of Total CHP+ Expenditures	0.27%	9.56%	0.73%	1.74%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	34,540	1,333	2,879
Number of CICP Providers [5]	0	3	1	3
CICP Expenditures	$0	$248,080,831	$10,126,630	$12,931,444
Percent of Total CICP Expenditures	0.00%	17.36%	0.71%	0.90%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Population (2013) [1]	5,658	14,790	16,003	826
Percent of Colorado Population (2013) [1]	0.11%	0.28%	0.30%	0.02%
Population (2007-11) [2]	5,358	14,608	15,385	790
Percent of Colorado Population (2007-11) [2]	0.11%	0.29%	0.31%	0.02%
Percent of Population 16+ in Labor Force (2007-11) [2]	70.84%	73.53%	73.02%	53.92%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	4.55%	8.95%	9.37%	7.89%
Percent of Population Living Below the Poverty Level (2007-11) [2]	6.90%	5.40%	7.50%	3.70%
Percent of Female-Headed Households (2007-11) [2]	5.29%	5.64%	5.06%	2.42%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	544	1,102	1,501	103
Percent of Population Who are Medicaid Clients	9.61%	7.45%	9.38%	12.47%
Medicaid Expenditures	$2,585,331	$4,782,806	$5,688,374	$252,027
Percent of Total Medicaid Expenditures	0.06%	0.12%	0.14%	0.01%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	55	200	221	12
Percent of Population Who are CHP+ Clients	0.97%	1.35%	1.38%	1.45%
CHP+ Expenditures	$153,366	$639,794	$679,762	$39,600
Percent of Total CHP+ Expenditures	0.08%	0.35%	0.37%	0.02%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	617	206	0
Number of CICP Providers [5]	0	1	1	0
CICP Expenditures	$0	$1,136,669	$710,920	$0
Percent of Total CICP Expenditures	0.00%	0.08%	0.05%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Population (2013) [1]	6,649	1,355	552,493	1,446
Percent of Colorado Population (2013) [1]	0.12%	0.03%	10.30%	0.03%
Population (2007-11) [2]	6,730	1,397	536,095	1,393
Percent of Colorado Population (2007-11) [2]	0.13%	0.03%	10.63%	0.03%
Percent of Population 16+ in Labor Force (2007-11) [2]	43.94%	70.28%	70.62%	67.95%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	18.61%	5.28%	10.15%	5.03%
Percent of Population Living Below the Poverty Level (2007-11) [2]	15.00%	12.10%	5.70%	10.60%
Percent of Female-Headed Households (2007-11) [2]	6.38%	6.14%	9.97%	7.58%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	1,735	203	56,076	255
Percent of Population Who are Medicaid Clients	26.10%	14.98%	10.15%	17.64%
Medicaid Expenditures	$10,764,799	$626,044	$387,857,229	$1,389,800
Percent of Total Medicaid Expenditures	0.27%	0.02%	9.67%	0.03%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	70	30	4,859	25
Percent of Population Who are CHP+ Clients	1.05%	2.21%	0.88%	1.73%
CHP+ Expenditures	$192,117	$104,603	$14,511,637	$67,345
Percent of Total CHP+ Expenditures	0.11%	0.06%	7.94%	0.04%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	225	0	0	0
Number of CICP Providers [5]	1	0	0	0
CICP Expenditures	$557,845	$0	$0	$0
Percent of Total CICP Expenditures	0.04%	0.00%	0.00%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Population (2013) [1]	8,163	7,746	55,999	322,437
Percent of Colorado Population (2013) [1]	0.15%	0.14%	1.04%	6.01%
Population (2007-11) [2]	8,210	7,372	51,443	300,870
Percent of Colorado Population (2007-11) [2]	0.16%	0.15%	1.02%	5.97%
Percent of Population 16+ in Labor Force (2007-11) [2]	61.05%	74.22%	69.12%	69.58%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	14.87%	29.57%	9.20%	8.82%
Percent of Population Living Below the Poverty Level (2007-11) [2]	8.70%	11.30%	5.70%	7.40%
Percent of Female-Headed Households (2007-11) [2]	8.78%	11.29%	7.93%	8.07%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	1,316	1,234	5,933	35,689
Percent of Population Who are Medicaid Clients	16.12%	15.93%	10.59%	11.07%
Medicaid Expenditures	$5,723,410	$4,334,158	$25,835,138	$182,606,343
Percent of Total Medicaid Expenditures	0.14%	0.11%	0.64%	4.55%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	209	117	800	3,468
Percent of Population Who are CHP+ Clients	2.56%	1.51%	1.43%	1.08%
CHP+ Expenditures	$560,887	$360,239	$2,432,647	$10,086,952
Percent of Total CHP+ Expenditures	0.31%	0.20%	1.33%	5.52%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	36	624	12,112
Number of CICP Providers [5]	0	1	1	4
CICP Expenditures	$0	$229,433	$6,243,274	$108,484,098
Percent of Total CICP Expenditures	0.00%	0.02%	0.44%	7.59%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Population (2013) [1]	15,730	5,471	22,447	151,303
Percent of Colorado Population (2013) [1]	0.29%	0.10%	0.42%	2.82%
Population (2007-11) [2]	15,385	5,443	22,541	146,562
Percent of Colorado Population (2007-11) [2]	0.31%	0.11%	0.45%	2.91%
Percent of Population 16+ in Labor Force (2007-11) [2]	58.30%	43.88%	66.11%	64.06%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	13.54%	11.91%	10.69%	9.25%
Percent of Population Living Below the Poverty Level (2007-11) [2]	13.30%	4.90%	12.00%	9.00%
Percent of Female-Headed Households (2007-11) [2]	10.76%	8.06%	12.47%	8.96%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	3,432	837	3,390	26,224
Percent of Population Who are Medicaid Clients	21.82%	15.30%	15.10%	17.33%
Medicaid Expenditures	$27,131,230	$4,192,181	$20,667,593	$126,932,009
Percent of Total Medicaid Expenditures	0.68%	0.10%	0.52%	3.17%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	186	57	289	1,963
Percent of Population Who are CHP+ Clients	1.18%	1.04%	1.29%	1.30%
CHP+ Expenditures	$546,105	$164,788	$876,770	$6,066,111
Percent of Total CHP+ Expenditures	0.30%	0.09%	0.48%	3.32%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	1,455	1,362	853	6,264
Number of CICP Providers [5]	1	1	1	4
CICP Expenditures	$3,717,410	$468,162	$4,468,064	$33,838,604
Percent of Total CICP Expenditures	0.26%	0.03%	0.31%	2.37%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Mineral**	**Moffat**	**Montezuma**	**Montrose**
Demographic Characteristics				
Population (2013) [1]	746	13,351	26,500	41,749
Percent of Colorado Population (2013) [1]	0.01%	0.25%	0.49%	0.78%
Population (2007-11) [2]	702	13,547	25,424	40,994
Percent of Colorado Population (2007-11) [2]	0.01%	0.27%	0.50%	0.81%
Percent of Population 16+ in Labor Force (2007-11) [2]	57.42%	70.23%	61.98%	62.28%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	3.45%	11.87%	12.47%	13.60%
Percent of Population Living Below the Poverty Level (2007-11) [2]	1.80%	9.00%	15.00%	10.60%
Percent of Female-Headed Households (2007-11) [2]	1.38%	7.11%	10.67%	8.50%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	53	2,345	5,481	8,310
Percent of Population Who are Medicaid Clients	7.11%	17.56%	20.68%	19.90%
Medicaid Expenditures	$225,426	$12,024,193	$29,256,090	$33,562,672
Percent of Total Medicaid Expenditures	0.01%	0.30%	0.73%	0.84%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	9	196	557	920
Percent of Population Who are CHP+ Clients	1.21%	1.47%	2.10%	2.20%
CHP+ Expenditures	$22,915	$611,354	$1,705,683	$2,734,509
Percent of Total CHP+ Expenditures	0.01%	0.33%	0.93%	1.50%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	1,134	673	1,854
Number of CICP Providers [5]	0	2	1	3
CICP Expenditures	$0	$3,022,175	$2,203,592	$10,963,294
Percent of Total CICP Expenditures	0.00%	0.21%	0.15%	0.77%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Morgan**	**Otero**	**Ouray**	**Park**
Demographic Characteristics				
Population (2013) [1]	28,985	19,115	4,773	17,193
Percent of Colorado Population (2013) [1]	0.54%	0.36%	0.09%	0.32%
Population (2007-11) [2]	28,200	18,791	4,445	16,168
Percent of Colorado Population (2007-11) [2]	0.56%	0.37%	0.09%	0.32%
Percent of Population 16+ in Labor Force (2007-11) [2]	64.81%	57.09%	61.78%	70.94%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	26.39%	18.05%	5.45%	3.82%
Percent of Population Living Below the Poverty Level (2007-11) [2]	11.80%	20.20%	3.30%	5.50%
Percent of Female-Headed Households (2007-11) [2]	13.43%	13.05%	3.29%	4.03%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	5,775	5,509	450	1,460
Percent of Population Who are Medicaid Clients	19.92%	28.82%	9.43%	8.49%
Medicaid Expenditures	$29,924,462	$32,256,216	$1,043,950	$5,567,882
Percent of Total Medicaid Expenditures	0.75%	0.80%	0.03%	0.14%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	455	300	95	174
Percent of Population Who are CHP+ Clients	1.57%	1.57%	1.99%	1.01%
CHP+ Expenditures	$1,294,122	$856,094	$255,784	$460,543
Percent of Total CHP+ Expenditures	0.71%	0.47%	0.14%	0.25%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	2,122	1,125	0	0
Number of CICP Providers [5]	2	1	0	0
CICP Expenditures	$7,351,027	$3,523,543	$0	$0
Percent of Total CICP Expenditures	0.51%	0.25%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Phillips**	**Pitkin**	**Prowers**	**Pueblo**
Demographic Characteristics				
Population (2013) [1]	4,353	17,888	12,640	164,965
Percent of Colorado Population (2013) [1]	0.08%	0.33%	0.24%	3.08%
Population (2007-11) [2]	4,380	17,000	12,539	159,072
Percent of Colorado Population (2007-11) [2]	0.09%	0.34%	0.25%	3.15%
Percent of Population 16+ in Labor Force (2007-11) [2]	62.55%	75.50%	63.82%	59.10%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	20.23%	17.37%	24.91%	14.01%
Percent of Population Living Below the Poverty Level (2007-11) [2]	11.10%	6.10%	18.60%	13.50%
Percent of Female-Headed Households (2007-11) [2]	5.72%	4.65%	12.01%	13.54%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	734	511	3,540	41,526
Percent of Population Who are Medicaid Clients	16.86%	2.86%	28.01%	25.17%
Medicaid Expenditures	$4,012,147	$2,375,197	$18,056,106	$252,560,588
Percent of Total Medicaid Expenditures	0.10%	0.06%	0.45%	6.30%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	72	87	267	1,713
Percent of Population Who are CHP+ Clients	1.65%	0.49%	2.11%	1.04%
CHP+ Expenditures	$213,952	$247,701	$771,382	$5,025,107
Percent of Total CHP+ Expenditures	0.12%	0.14%	0.42%	2.75%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	98	301	2,149	15,728
Number of CICP Providers [5]	1	1	2	3
CICP Expenditures	$220,248	$2,718,605	$3,054,784	$167,050,426
Percent of Total CICP Expenditures	0.02%	0.19%	0.21%	11.69%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Rio Blanco**	**Rio Grande**	**Routt**	**Saguache**
Demographic Characteristics				
Population (2013) [1]	6,817	12,246	24,279	6,615
Percent of Colorado Population (2013) [1]	0.13%	0.23%	0.45%	0.12%
Population (2007-11) [2]	6,728	11,925	23,385	6,189
Percent of Colorado Population (2007-11) [2]	0.13%	0.24%	0.46%	0.12%
Percent of Population 16+ in Labor Force (2007-11) [2]	66.94%	57.29%	77.55%	64.10%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	9.80%	25.41%	4.43%	33.89%
Percent of Population Living Below the Poverty Level (2007-11) [2]	3.20%	12.40%	5.20%	18.80%
Percent of Female-Headed Households (2007-11) [2]	5.63%	8.77%	6.90%	10.82%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	858	3,325	1,858	1,718
Percent of Population Who are Medicaid Clients	12.59%	27.15%	7.65%	25.97%
Medicaid Expenditures	$3,990,635	$15,464,136	$9,887,442	$5,947,941
Percent of Total Medicaid Expenditures	0.10%	0.39%	0.25%	0.15%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	68	267	388	122
Percent of Population Who are CHP+ Clients	1.00%	2.18%	1.60%	1.84%
CHP+ Expenditures	$200,202	$775,610	$1,147,629	$354,397
Percent of Total CHP+ Expenditures	0.11%	0.42%	0.63%	0.19%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	565	688	0
Number of CICP Providers [5]	0	1	1	0
CICP Expenditures	$0	$1,148,471	$5,697,500	$0
Percent of Total CICP Expenditures	0.00%	0.08%	0.40%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**San Juan**	**San Miguel**	**Sedgwick**	**Summit**
Demographic Characteristics				
Population (2013) [1]	695	8,212	2,421	29,811
Percent of Colorado Population (2013) [1]	0.01%	0.15%	0.05%	0.56%
Population (2007-11) [2]	747	7,432	2,389	27,753
Percent of Colorado Population (2007-11) [2]	0.01%	0.15%	0.05%	0.55%
Percent of Population 16+ in Labor Force (2007-11) [2]	77.73%	83.09%	59.90%	81.12%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	7.25%	10.40%	11.42%	15.19%
Percent of Population Living Below the Poverty Level (2007-11) [2]	9.60%	4.70%	9.50%	6.40%
Percent of Female-Headed Households (2007-11) [2]	8.73%	5.03%	7.44%	5.49%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	89	694	472	1,945
Percent of Population Who are Medicaid Clients	12.81%	8.45%	19.50%	6.52%
Medicaid Expenditures	$232,520	$1,360,107	$3,231,899	$5,917,362
Percent of Total Medicaid Expenditures	0.01%	0.03%	0.08%	0.15%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	14	108	32	346
Percent of Population Who are CHP+ Clients	2.02%	1.32%	1.32%	1.16%
CHP+ Expenditures	$37,196	$337,748	$81,220	$983,668
Percent of Total CHP+ Expenditures	0.02%	0.18%	0.04%	0.54%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	0	394	74	1,049
Number of CICP Providers [4]	0	1	1	1
CICP Expenditures	$0	$205,933	$152,788	$218,511
Percent of Total CICP Expenditures	0.00%	0.01%	0.01%	0.02%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Teller**	**Washington**	**Weld**	**Yuma**
Demographic Characteristics				
Population (2013) [1]	24,851	4,604	276,076	10,264
Percent of Colorado Population (2013) [1]	0.46%	0.09%	5.15%	0.19%
Population (2007-11) [2]	23,163	4,796	253,552	10,032
Percent of Colorado Population (2007-11) [2]	0.46%	0.10%	5.03%	0.20%
Percent of Population 16+ in Labor Force (2007-11) [2]	64.40%	61.75%	68.22%	64.07%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	4.54%	5.48%	18.78%	15.90%
Percent of Population Living Below the Poverty Level (2007-11) [2]	5.20%	8.20%	9.90%	6.10%
Percent of Female-Headed Households (2007-11) [2]	8.32%	6.51%	9.72%	5.84%
Medicaid Characteristics (FY 2013-14) [3]				
Average Number of Medicaid Clients per Month	2,877	668	44,614	1,832
Percent of Population Who are Medicaid Clients	11.58%	14.51%	16.16%	17.85%
Medicaid Expenditures	$13,989,662	$3,584,251	$207,702,536	$9,675,297
Percent of Total Medicaid Expenditures	0.35%	0.09%	5.18%	0.24%
Children's Basic Health Plan (CHP+) Characteristics (FY 2013-14) [4]				
Average Number of CHP+ Clients per Month	242	89	4,124	174
Percent of Population Who are CHP+ Clients	0.97%	1.93%	1.49%	1.70%
CHP+ Expenditures	$649,373	$242,713	$12,010,865	$478,853
Percent of Total CHP+ Expenditures	0.36%	0.13%	6.57%	0.26%
Colorado Indigent Care Program (CICP) Characteristics (FY 2012-13)				
Unduplicated Client Count	451	0	29,429	499
Number of CICP Providers [5]	1	0	3	2
CICP Expenditures	$2,063,338	$0	$75,460,835	$915,801
Percent of Total CICP Expenditures	0.14%	0.00%	5.28%	0.06%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?

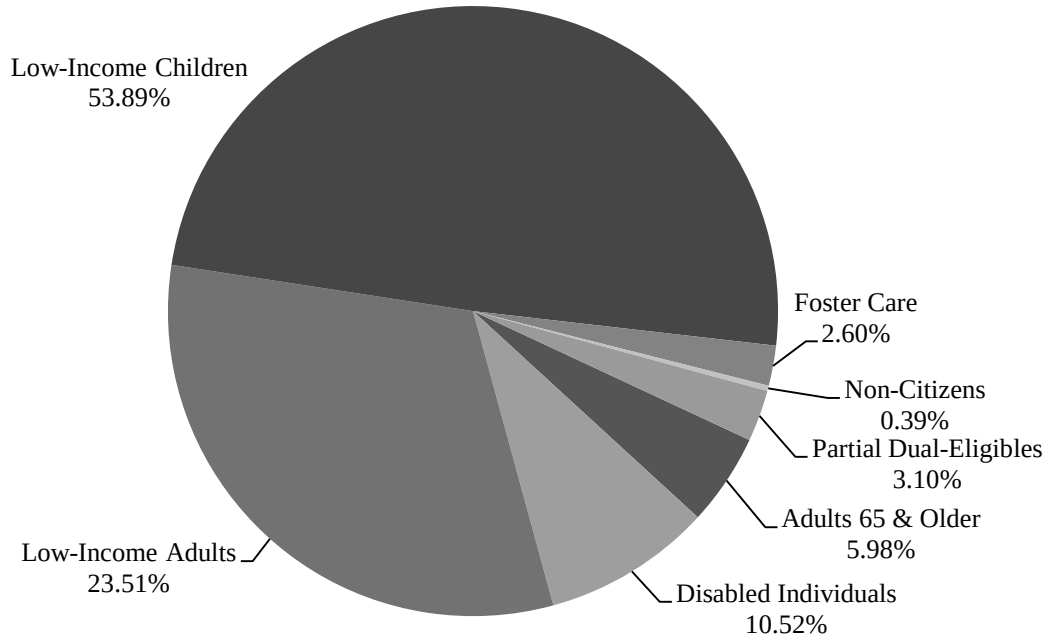
3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

4) CHP+ caseload does not include "CHP+ at Work" clients

5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

MEDICAID CASELOAD

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2013-14.[6]



[6] Source: November 1, 2014 FY 2015-16 Budget Request, Exhibit B, "Medicaid Caseload Forecast"

A. Clients

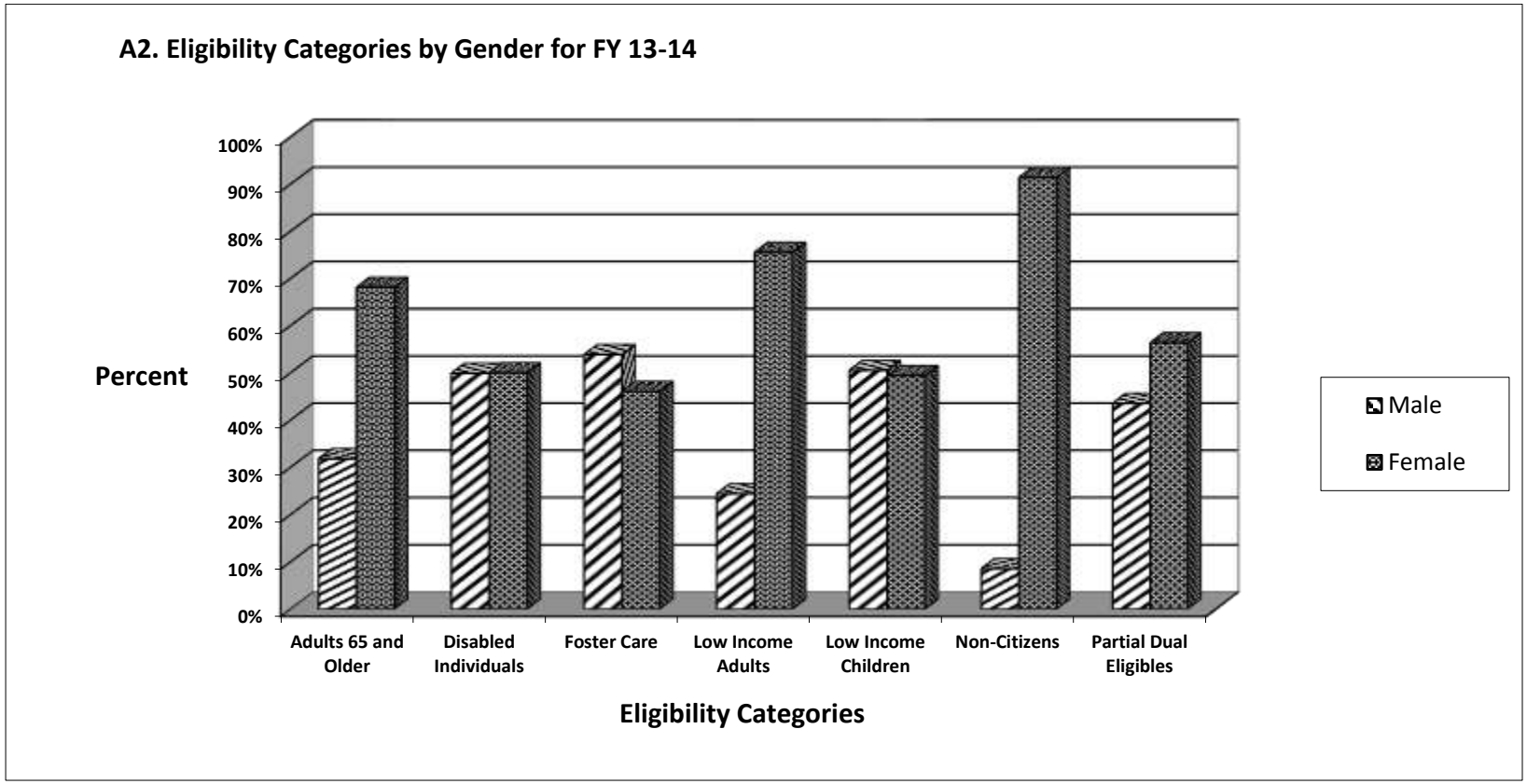
A1. 2014 Federal Poverty Levels

The table below reports the federal poverty levels (FPLs) for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add $4,060 for each additional family member.

2014 Federal Poverty Guidelines for Annual Income									
Family Size	**100%**	**120%**	**133%**	**150%**	**175%**	**185%**	**190%**	**200%**	**250%**
1	$11,670	$14,004	$15,521	$15,755	$17,505	$20,423	$21,590	$23,340	$29,175
2	$15,730	$18,876	$20,921	$21,236	$23,595	$27,528	$29,101	$31,460	$39,325
3	$19,790	$23,748	$26,321	$26,717	$29,685	$34,633	$36,612	$39,580	$49,475
4	$23,850	$28,620	$31,721	$32,198	$35,775	$41,738	$44,123	$47,700	$59,625
5	$27,910	$33,492	$37,120	$37,679	$41,865	$48,843	$51,634	$55,820	$69,775
6	$31,970	$38,364	$42,520	$43,160	$47,955	$55,948	$59,145	$63,940	$79,925
7	$36,030	$43,236	$47,920	$48,641	$54,045	$63,053	$66,656	$72,060	$90,075
8	$40,090	$48,108	$53,320	$54,122	$60,135	$70,158	$74,167	$80,180	$100,225

Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2014-Federal-Poverty-level-charts.pdf

A2. Eligibility Categories by Gender for FY 2013-14[7]



[7] Source: The Department's decision support system (MMIS-DSS)
1) Low-Income Adults also includes Baby Care Program Adults and Breast and Cervical Cancer Program Clients.
2) Disabled Individuals includes Disabled Adults 60 to 64 and Disabled Individuals to 59.
3) Partial Dual Eligibles includes Qualified and Supplemental Low-Income Medicare Beneficiaries.
4) Percent based on member months in each category.

A3. Medicaid Enrollment by Type of Managed Care Provider

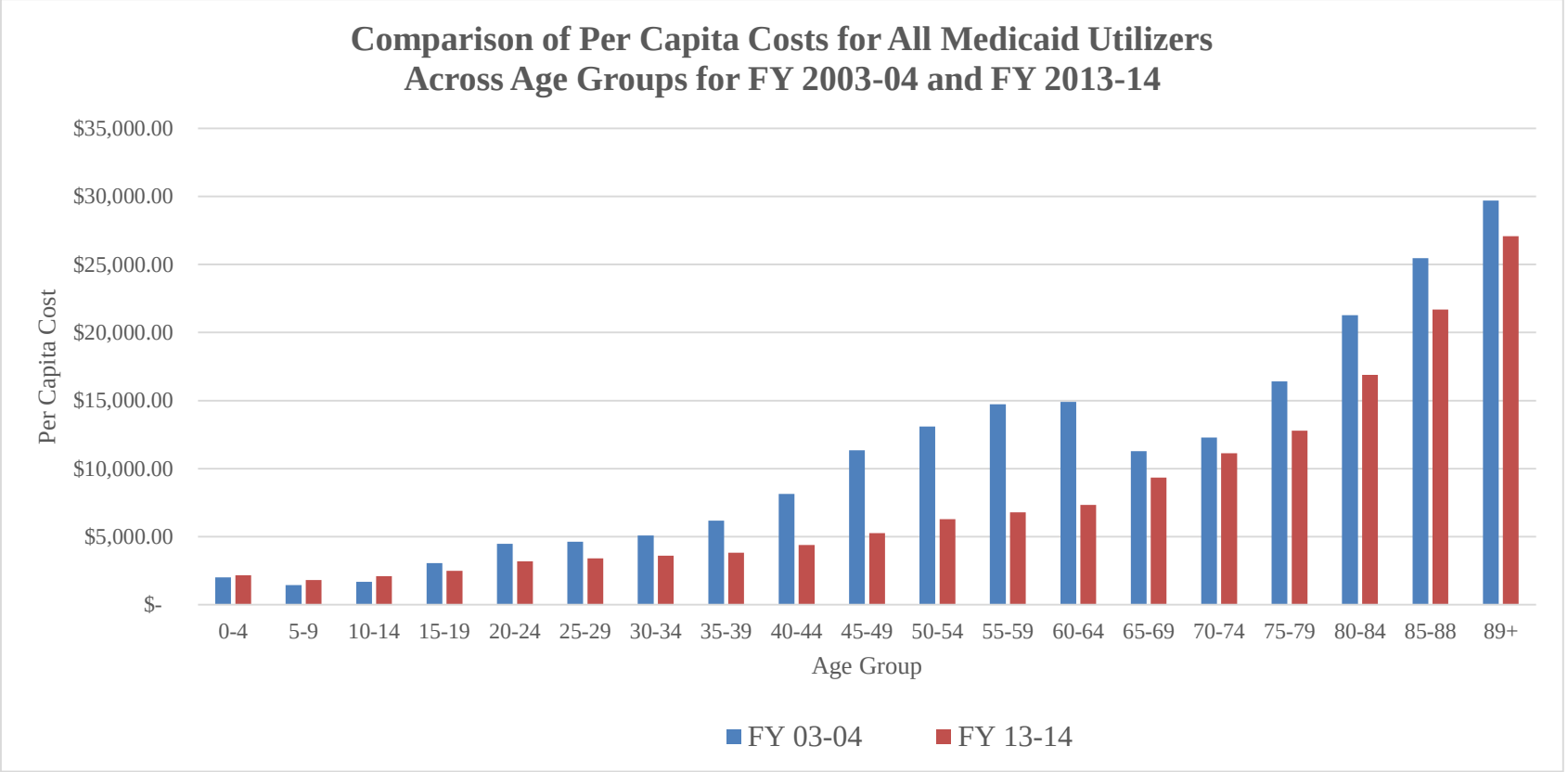
The following table shows the breakdown by client count for FY 2009-10 through FY 2013-14 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures and, as a result, may cause the fee-for-service counts to be underrepresented.[8]

Average Medicaid Enrollment for FY 2009-10 through FY 2013-14					
Membership Category	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
HMOs and Prepaid Inpatient Health Plans	61,047	66,477	70,351	75,416	93,232
Primary Care Physician Program	23,240	23,380	23,264	22,953	26,790
Fee-for-Service	413,902	470,865	526,349	580,437	958,686
TOTAL	**498,189**	**560,722**	**619,964**	**678,806**	**1,078,708**

[8] Department of Health Care Policy and Financing June 2014 Premiums, Caseload, and Expenditures Report (JBC Monthly Report).
Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organizations, and the Primary Care Physician Program.

B. Services

B1. Paid Medical Services Per-Capita Costs (from all claims) Across Age Groups[9]



[9] Source: Medicaid paid claims. Financial transactions and other accounting adjustments are not included in the expenditures by age group.

B2. FY 2013-14 Services by County

Exhibits B2a and B2b show client counts, expenditures, and average costs of the following medical services county by average monthly client count and average cost per full-time equivalent (FTE) client.

Acute Care, including:

- Federal Qualified Health Centers (FQHCs)
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Prescription Drugs
- Inpatient Hospital
- Outpatient Hospital

B3. Client Counts for Long-Term Care and Home- and Community-Based Services

Exhibit B3a though B3c shows client counts, expenditures, and average costs for Long-Term Care and Home Health and Long-Term Care Services, including:

- Home- and Community-Based Services (HCBS)
- Program for All-Inclusive Care for the Elderly (PACE)
- Home Health
- Nursing Facilities

B4. FY 2013-14 Deliveries

Exhibit B4a through B4e show client counts, expenditures, and average costs for various deliveries in Medicaid, including:

- Deliveries by County
- Delivery Types
- Age Group of Mother
- Low Birthweight, Preterm, and Neonatal Intensive Care Unit

- Neonatal Intensive Care Unit

B5. FY 2013-14 Top Tens

Exhibits B5a through B5j show expenditure and utilization for the top 10 diagnoses and procedures for the following:

- Inpatient Hospital
- Outpatient Hospital
- Federal Qualified Health Centers (FQHCs)
- Rural Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Dental
- Laboratory
- Durable Medical Equipment and Supplies

Exhibits B5k and B5l show the top 10 prescription drug expenditures and the top ten prescription drugs by number of prescriptions filled, in total and pre and post implementation of Medicare Part D.

The following should be noted:

- Clients with no county designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., the Medicaid Management Information System, or MMIS) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home- and Community-Based Services waivers: Elderly, Blind and Disabled; Persons with Mental Illness; Persons Living with AIDS; Persons with Brain Injury; Children's; Children with Autism; Pediatric Hospice Waiver; and Spinal Cord Injury (effective July 2012).
- The Department of Human Services administers the following Home- and Community-Based Services waivers: Developmentally Disabled; Supported Living Services; Children's Extensive Support; and Children's Habilitation Residential Program.

- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables B5a and B5b). Research and reasonableness were used to determine the DRG categories. The naming of DRG categories was completed through consultation of the ICD-10 (International Classification of Diseases). There is a group called Non-Specific Symptoms, Disorders or Procedures which was created to minimize the number of DRG categories. Since the DRG descriptions were sometimes referring to diseases and sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on the first three digits of the ICD-10 codes.
- For the top 10 prescription drug tables, the number of prescriptions filled was used instead of the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. In addition, claims where the payment was zero were excluded from the analysis.
- The totals at the bottom of each of the top-10 tables reflect the sum of unique client count/count of services/expenditures for the top-10 groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

B2a: FY 2013-14 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	32,729	81,037	64,195	7,827	47,190
Alamosa	3,977	3,760	3,733	382	2,472
Arapahoe	14,871	79,631	61,641	7,634	43,963
Archuleta	48	1,423	1,248	131	937
Baca	201	567	536	62	411
Bent	923	954	1,078	69	700
Boulder	12,963	25,178	20,048	2,296	14,104
Broomfield	1,020	3,813	2,989	367	1,996
Chaffee	104	2,050	1,695	164	1,297
Cheyenne	62	195	211	NR	142
Clear Creek	231	785	667	71	403
Conejos	1,566	1,704	1,979	173	1,337
Costilla	947	841	834	66	527
Crowley	377	792	744	55	518
Custer	48	425	353	41	229
Delta	146	2,944	2,144	232	1,632
Denver	44,621	80,181	65,894	9,028	48,777
Dolores	224	320	270	NR	187
Douglas	578	12,807	10,091	1,029	6,056
Eagle	1,162	4,089	2,913	408	2,114
Elbert	569	1,497	1,345	155	833
El Paso	44,244	82,508	70,020	7,089	51,917
Fremont	1,017	7,276	6,648	584	4,601
Garfield	3,375	6,945	5,931	797	4,350
Gilpin	259	500	398	51	289
Grand	60	1,267	946	112	669
Gunnison	46	1,617	1,008	103	858
Hinsdale	37	72	53	NR	58
Huerfano	138	1,482	1,243	106	947
Jackson	NR	168	134	NR	100
Jefferson	11,170	51,791	42,027	4,774	27,760
Kiowa	121	174	215	NR	145
Kit Carson	217	1,044	950	100	658
Lake	89	1,251	933	119	665
La Plata	288	5,839	4,365	518	3,201

B2a: FY 2013-14 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	10,890	34,992	28,229	2,801	17,888
Las Animas	130	2,796	2,556	235	2,079
Lincoln	555	642	659	67	393
Logan	1,091	2,688	2,613	252	1,942
Mesa	221	12,650	9,171	1,153	6,267
Mineral	NR	72	52	NR	43
Moffat	1,023	2,157	1,766	217	1,247
Montezuma	238	4,619	4,334	423	3,084
Montrose	453	3,813	2,598	297	1,937
Morgan	2,433	4,699	3,984	508	3,130
Otero	2,733	4,718	4,299	343	3,063
Ouray	NR	271	213	NR	115
Park	224	1,485	1,192	115	637
Phillips	126	494	537	63	399
Pitkin	254	521	475	65	299
Prowers	2,811	2,676	2,814	242	1,899
Pueblo	13,634	38,453	33,249	3,249	24,513
Rio Blanco	51	473	490	47	364
Rio Grande	2,325	2,578	2,589	259	1,751
Routt	359	2,116	1,528	156	979
Saguache	1,415	1,241	1,189	116	829
San Juan	NR	87	59	NR	67
San Miguel	257	519	406	39	168
Sedgwick	58	312	384	32	266
Summit	643	2,121	1,468	203	750
Teller	1,538	2,667	2,309	217	1,791
Washington	162	495	513	44	331
Weld	19,014	39,732	32,038	3,980	23,108
Yuma	269	1,439	1,237	137	853
Suppressed Counties	83	-	-	117	-
STATEWIDE	**232,426**	**617,765**	**508,208**	**58,689**	**359,214**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. ”NR” denotes county included in "Suppressed Counties" category.

B2b: FY 2013-14 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$18,138,423	$53,404,982	$47,604,131	$60,192,534	$55,900,759
Alamosa	$2,389,972	$1,874,614	$2,711,184	$2,447,491	$2,230,242
Arapahoe	$7,388,556	$51,864,414	$51,766,656	$59,715,539	$49,649,770
Archuleta	$19,948	$807,631	$580,115	$1,119,988	$1,160,570
Baca	$94,873	$288,521	$543,197	$455,810	$349,541
Bent	$519,277	$427,822	$1,526,377	$651,383	$647,063
Boulder	$6,730,171	$16,824,348	$18,041,458	$16,543,915	$13,903,833
Broomfield	$519,540	$2,312,665	$2,554,512	$2,512,714	$2,137,051
Chaffee	$38,586	$1,028,998	$1,583,909	$1,381,870	$1,604,169
Cheyenne	$24,342	$105,506	$142,336	NR	$131,962
Clear Creek	$107,706	$566,081	$853,686	$554,844	$496,948
Conejos	$826,197	$767,110	$1,419,605	$1,049,787	$1,524,562
Costilla	$567,894	$478,672	$930,208	$824,773	$573,290
Crowley	$172,464	$374,589	$808,722	$300,323	$354,855
Custer	$24,140	$324,516	$294,544	$424,667	$287,024
Delta	$84,587	$1,181,757	$1,239,026	$1,989,166	$1,794,932
Denver	$23,827,972	$50,806,986	$50,107,770	$88,351,610	$58,638,313
Dolores	$110,287	$166,020	$157,448	NR	$262,983
Douglas	$232,797	$8,840,628	$10,364,181	$7,454,978	$7,900,702
Eagle	$556,586	$1,972,041	$1,878,505	$3,699,481	$2,383,405
Elbert	$208,218	$1,026,644	$1,342,216	$1,199,749	$1,100,557
El Paso	$26,276,912	$56,408,558	$63,924,930	$49,182,863	$51,871,888
Fremont	$415,138	$4,497,304	$6,481,059	$4,709,177	$3,878,169
Garfield	$1,782,142	$3,339,833	$3,857,079	$5,616,040	$6,337,009
Gilpin	$112,125	$318,661	$353,314	$539,418	$379,475
Grand	$24,587	$844,883	$642,085	$1,143,890	$1,217,209
Gunnison	$16,830	$714,408	$597,152	$667,325	$1,068,860
Hinsdale	$16,361	$29,632	$57,539	NR	$65,283
Huerfano	$82,488	$980,313	$1,323,052	$916,104	$807,040
Jackson	NR	$81,222	$59,092	NR	$188,849
Jefferson	$5,876,765	$36,009,235	$41,671,526	$37,312,939	$35,137,120
Kiowa	$70,040	$68,201	$188,917	NR	$124,520
Kit Carson	$52,990	$482,827	$503,726	$695,551	$627,636
Lake	$30,644	$669,850	$709,216	$1,023,619	$759,114
La Plata	$105,272	$3,434,869	$3,257,912	$3,538,866	$3,026,123

B2b: FY 2013-14 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$5,178,123	$21,470,440	$26,915,313	$18,047,957	$19,580,520
Las Animas	$78,800	$1,992,679	$2,224,292	$1,890,322	$2,622,860
Lincoln	$264,730	$352,384	$465,150	$469,262	$543,611
Logan	$540,094	$1,502,602	$3,342,454	$2,094,932	$2,233,013
Mesa	$75,394	$5,873,361	$4,655,416	$8,257,701	$7,079,492
Mineral	NR	$46,953	$68,829	NR	$44,689
Moffat	$538,333	$1,095,414	$1,386,879	$1,725,717	$1,978,971
Montezuma	$93,248	$2,360,286	$3,390,828	$3,396,026	$3,261,076
Montrose	$228,495	$1,462,391	$1,159,390	$2,093,246	$1,958,284
Morgan	$1,268,057	$2,531,627	$3,254,752	$3,405,224	$3,376,842
Otero	$1,522,542	$2,146,839	$4,288,668	$2,963,048	$2,260,549
Ouray	NR	$96,657	$141,032	NR	$92,295
Park	$78,696	$825,115	$1,065,626	$919,898	$1,045,634
Phillips	$41,496	$221,500	$602,568	$312,489	$525,381
Pitkin	$121,640	$286,118	$602,950	$496,772	$529,816
Prowers	$1,899,175	$1,028,389	$2,379,182	$1,640,175	$1,778,336
Pueblo	$8,397,708	$26,170,086	$34,901,755	$25,653,923	$25,569,171
Rio Blanco	$23,843	$168,589	$443,145	$297,721	$631,387
Rio Grande	$1,402,527	$1,215,419	$1,938,438	$1,577,691	$1,646,899
Routt	$135,326	$1,127,880	$1,112,989	$1,511,729	$1,432,345
Saguache	$862,782	$492,720	$1,030,802	$693,264	$780,423
San Juan	NR	$29,837	$34,804	NR	$61,323
San Miguel	$95,468	$206,414	$206,725	$328,415	$177,832
Sedgwick	$21,092	$112,527	$296,561	$213,806	$262,766
Summit	$149,192	$1,258,004	$1,097,541	$1,443,495	$1,057,223
Teller	$798,487	$1,586,826	$2,070,017	$1,738,914	$1,783,722
Washington	$56,127	$209,594	$551,309	$391,679	$414,878
Weld	$9,818,121	$25,603,073	$28,354,699	$28,620,411	$24,262,839
Yuma	$77,191	$680,258	$1,126,948	$1,001,164	$1,488,843
Suppressed Counties	$39,533	$0	$0	$725,851	$0
STATEWIDE	**$131,250,924**	**$405,478,327**	**$449,185,448**	**$468,127,247**	**$417,001,845**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.

B2c: FY 2013-14 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$554	$659	$742	$7,690	$1,185
Alamosa	$601	$499	$726	$6,407	$902
Arapahoe	$497	$651	$840	$7,822	$1,129
Archuleta	$416	$568	$465	$8,550	$1,239
Baca	$472	$509	$1,013	$7,352	$850
Bent	$563	$448	$1,416	$9,440	$924
Boulder	$519	$668	$900	$7,206	$986
Broomfield	$509	$607	$855	$6,847	$1,071
Chaffee	$371	$502	$934	$8,426	$1,237
Cheyenne	$393	$541	$675	$7,000	$929
Clear Creek	$466	$721	$1,280	$7,815	$1,233
Conejos	$528	$450	$717	$6,068	$1,140
Costilla	$600	$569	$1,115	$12,497	$1,088
Crowley	$457	$473	$1,087	$5,460	$685
Custer	$503	$764	$834	$10,358	$1,253
Delta	$579	$401	$578	$8,574	$1,100
Denver	$534	$634	$760	$9,786	$1,202
Dolores	$492	$519	$583	$6,000	$1,406
Douglas	$403	$690	$1,027	$7,245	$1,305
Eagle	$479	$482	$645	$9,067	$1,127
Elbert	$366	$686	$998	$7,740	$1,321
El Paso	$594	$684	$913	$6,938	$999
Fremont	$408	$618	$975	$8,064	$843
Garfield	$528	$481	$650	$7,046	$1,457
Gilpin	$433	$637	$888	$10,577	$1,313
Grand	$410	$667	$679	$10,213	$1,819
Gunnison	$366	$442	$592	$6,479	$1,246
Hinsdale	$442	$412	$1,086	$5,822	$1,126
Huerfano	$598	$661	$1,064	$8,642	$852
Jackson	$567	$483	$441	$5,830	$1,888
Jefferson	$526	$695	$992	$7,816	$1,266
Kiowa	$579	$392	$879	$3,960	$859
Kit Carson	$244	$462	$530	$6,956	$954
Lake	$344	$535	$760	$8,602	$1,142
La Plata	$366	$588	$746	$6,832	$945

B2c: FY 2013-14 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$475	$614	$953	$6,443	$1,095
Las Animas	$606	$713	$870	$8,044	$1,262
Lincoln	$477	$549	$706	$7,004	$1,383
Logan	$495	$559	$1,279	$8,313	$1,150
Mesa	$341	$464	$508	$7,162	$1,130
Mineral	$377	$652	$1,324	$11,362	$1,039
Moffat	$526	$508	$785	$7,953	$1,587
Montezuma	$392	$511	$782	$8,028	$1,057
Montrose	$504	$384	$446	$7,048	$1,011
Morgan	$521	$539	$817	$6,703	$1,079
Otero	$557	$455	$998	$8,639	$738
Ouray	$363	$357	$662	$6,995	$803
Park	$351	$556	$894	$7,999	$1,641
Phillips	$329	$448	$1,122	$4,960	$1,317
Pitkin	$479	$549	$1,269	$7,643	$1,772
Prowers	$676	$384	$845	$6,778	$936
Pueblo	$616	$681	$1,050	$7,896	$1,043
Rio Blanco	$468	$356	$904	$6,334	$1,735
Rio Grande	$603	$471	$749	$6,091	$941
Routt	$377	$533	$728	$9,691	$1,463
Saguache	$610	$397	$867	$5,976	$941
San Juan	$554	$343	$590	$5,352	$915
San Miguel	$371	$398	$509	$8,421	$1,059
Sedgwick	$364	$361	$772	$6,681	$988
Summit	$232	$593	$748	$7,111	$1,410
Teller	$519	$595	$896	$8,013	$996
Washington	$346	$423	$1,075	$8,902	$1,253
Weld	$516	$644	$885	$7,191	$1,050
Yuma	$287	$473	$911	$7,308	$1,745
STATEWIDE	**$565**	**$656**	**$884**	**$7,976**	**$1,161**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.

B3a: FY 2013-14 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	1,959	845	401	1,658	1,228
Alamosa	333	60	0	128	99
Arapahoe	3,043	1,264	407	1,821	1,249
Archuleta	85	NR	0	NR	65
Baca	102	NR	0	NR	66
Bent	99	NR	0	45	61
Boulder	1,317	538	NR	692	688
Broomfield	201	85	NR	116	152
Chaffee	108	48	0	63	73
Cheyenne	NR	NR	0	0	NR
Clear Creek	47	NR	0	NR	NR
Conejos	198	NR	0	69	65
Costilla	188	NR	0	60	NR
Crowley	100	NR	0	NR	NR
Custer	NR	NR	0	NR	0
Delta	341	66	109	130	118
Denver	4,649	811	745	2,216	1,937
Dolores	NR	NR	0	NR	NR
Douglas	622	223	NR	292	244
Eagle	51	NR	0	49	NR
Elbert	54	NR	NR	NR	NR
El Paso	2,860	1,020	233	1,970	1,465
Fremont	468	116	0	152	380
Garfield	327	110	0	96	209
Gilpin	53	NR	0	NR	NR
Grand	52	NR	0	NR	NR
Gunnison	64	NR	0	32	34
Hinsdale	NR	0	0	NR	0
Huerfano	151	34	0	55	74
Jackson	NR	NR	0	NR	NR
Jefferson	2,374	1,051	443	1,373	1,592
Kiowa	NR	NR	0	0	NR
Kit Carson	60	NR	0	NR	NR
Lake	NR	NR	0	100	NR
La Plata	353	64	0	NR	127

B3a: FY 2013-14 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	1,544	537	NR	892	895
Las Animas	429	72	0	57	114
Lincoln	72	NR	0	NR	NR
Logan	203	98	0	52	110
Mesa	1,623	424	0	376	505
Mineral	NR	NR	0	0	NR
Moffat	80	33	0	NR	62
Montezuma	360	42	0	117	148
Montrose	356	121	157	127	187
Morgan	279	55	NR	86	218
Otero	463	90	0	192	176
Ouray	NR	NR	0	NR	NR
Park	33	NR	0	NR	0
Phillips	51	NR	0	NR	41
Pitkin	NR	0	0	NR	NR
Prowers	301	42	0	72	85
Pueblo	1,968	603	176	1,426	750
Rio Blanco	63	NR	0	NR	40
Rio Grande	165	NR	0	101	115
Routt	49	36	0	NR	57
Saguache	133	NR	0	44	NR
San Juan	NR	0	0	NR	0
San Miguel	NR	NR	0	NR	NR
Sedgwick	32	NR	0	NR	NR
Summit	NR	NR	0	NR	NR
Teller	135	NR	0	62	47
Washington	36	NR	0	NR	NR
Weld	1,552	432	NR	1,042	670
Yuma	134	NR	0	NR	89
Suppressed Counties	180	261	NR	282	255
STATEWIDE	**30,500**	**9,181**	**2,686**	**14,916**	**14,490**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.

B3b: FY 2013-14 Expenditures for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	$19,564,514	$30,910,755	$14,812,459	$18,609,308	$49,912,291
Alamosa	$2,795,886	$2,815,390	$0	$357,616	$3,687,783
Arapahoe	$35,326,209	$49,440,443	$14,964,687	$24,078,781	$51,783,326
Archuleta	$906,618	NR	$0	NR	$2,154,073
Baca	$282,803	NR	$0	NR	$3,079,546
Bent	$459,810	NR	$0	$399,339	$2,261,034
Boulder	$12,715,514	$20,005,581	NR	$7,826,344	$26,221,236
Broomfield	$1,887,967	$2,765,907	NR	$1,721,357	$4,793,278
Chaffee	$661,287	$1,628,670	$0	$456,079	$2,267,282
Cheyenne	NR	NR	$0	$0	NR
Clear Creek	$400,101	NR	$0	NR	NR
Conejos	$1,481,373	NR	$0	$233,764	$2,425,917
Costilla	$1,328,115	NR	$0	$198,913	NR
Crowley	$736,896	NR	$0	NR	NR
Custer	NR	NR	$0	NR	$0
Delta	$3,420,773	$2,137,582	$3,860,175	$998,881	$4,023,922
Denver	$59,814,514	$25,890,031	$27,967,765	$24,618,344	$82,232,947
Dolores	NR	NR	$0	NR	NR
Douglas	$7,355,103	$5,383,011	NR	$5,252,429	$8,976,455
Eagle	$549,002	NR	$0	$109,965	NR
Elbert	$597,232	NR	NR	NR	$1,054,592
El Paso	$37,120,543	$35,586,060	$8,333,213	$43,356,063	$58,273,643
Fremont	$3,585,921	$5,434,389	$0	$1,814,421	$12,740,791
Garfield	$2,925,801	$5,385,580	$0	$476,382	$8,967,891
Gilpin	$606,221	NR	$0	NR	NR
Grand	$486,359	NR	$0	NR	NR
Gunnison	$540,158	NR	$0	$113,707	$1,697,164
Hinsdale	NR	$0	$0	NR	$0
Huerfano	$1,528,620	$1,088,560	$0	$137,676	$2,491,702
Jackson	NR	NR	$0	NR	NR
Jefferson	$27,114,142	$38,168,198	$15,918,593	$19,932,593	$66,898,156
Kiowa	NR	NR	$0	$0	NR
Kit Carson	$465,839	NR	$0	NR	NR
Lake	NR	NR	$0	$95,385	NR
La Plata	$3,608,069	$2,013,050	$0	NR	$4,312,289

B3b: FY 2013-14 Expenditures for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$11,977,653	$20,389,116	NR	$9,332,765	$32,963,159
Las Animas	$6,871,251	$2,275,380	$0	$157,197	$4,693,517
Lincoln	$635,893	NR	$0	NR	NR
Logan	$1,752,640	$4,098,587	$0	$412,876	$2,874,136
Mesa	$23,220,505	$27,864,166	$0	$3,347,025	$17,571,598
Mineral	NR	NR	$0	$0	NR
Moffat	$596,856	$1,609,895	$0	NR	$2,241,341
Montezuma	$4,108,310	$1,377,564	$0	$1,009,276	$5,259,403
Montrose	$2,810,397	$4,381,304	$5,676,953	$1,861,994	$6,346,460
Morgan	$2,323,624	$1,740,259	NR	$334,834	$7,933,781
Otero	$2,748,395	$4,155,157	$0	$2,128,857	$5,864,816
Ouray	NR	NR	$0	NR	NR
Park	$273,990	NR	$0	NR	$0
Phillips	$295,655	NR	$0	NR	$1,268,420
Pitkin	NR	$0	$0	NR	NR
Prowers	$1,149,071	$1,975,872	$0	$390,745	$3,422,268
Pueblo	$16,782,968	$32,500,258	$6,666,212	$21,875,750	$26,798,667
Rio Blanco	$418,600	NR	$0	NR	$1,618,299
Rio Grande	$1,030,404	NR	$0	$325,944	$3,848,766
Routt	$225,424	$1,464,777	$0	NR	$2,772,926
Saguache	$1,066,747	NR	$0	$105,652	NR
San Juan	NR	$0	$0	NR	$0
San Miguel	NR	NR	$0	NR	NR
Sedgwick	$224,692	NR	$0	NR	NR
Summit	NR	NR	$0	NR	NR
Teller	$1,527,895	NR	$0	$1,421,351	$1,788,068
Washington	$193,258	NR	$0	NR	NR
Weld	$18,376,980	$16,606,834	NR	$10,003,561	$23,317,663
Yuma	$1,098,043	NR	$0	NR	$2,900,240
Suppressed Counties	$2,307,756	$7,273,094	NR	$2,483,603	$8,685,688
STATEWIDE	**$330,282,400**	**$356,365,469**	**$98,531,587**	**$206,094,923**	**$561,369,940**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.

B3c: FY 2013-14 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	$9,987	$36,581	$36,939	$11,224	$40,645
Alamosa	$8,396	$46,923	$0	$2,794	$37,250
Arapahoe	$11,609	$39,114	$36,768	$13,223	$41,460
Archuleta	$10,666	$5,354	$0	$1,212	$33,140
Baca	$2,773	$39,663	$0	$9,672	$46,660
Bent	$4,645	$55,223	$0	$8,874	$37,066
Boulder	$9,655	$37,185	$14,561	$11,310	$38,112
Broomfield	$9,393	$32,540	$26,405	$14,839	$31,535
Chaffee	$6,123	$33,931	$0	$7,239	$31,059
Cheyenne	$1,899	$7,430	$0	$0	$47,152
Clear Creek	$8,513	$19,455	$0	$6,280	$10,434
Conejos	$7,482	$10,628	$0	$3,388	$37,322
Costilla	$7,064	$14,629	$0	$3,315	$15,695
Crowley	$7,369	$864	$0	$2,700	$42,901
Custer	$9,462	$1,789	$0	$4,527	$0
Delta	$10,032	$32,388	$35,414	$7,684	$34,101
Denver	$12,866	$31,924	$37,541	$11,109	$42,454
Dolores	$22,249	$7,675	$0	$4,950	$1,550
Douglas	$11,825	$24,139	$6,067	$17,988	$36,789
Eagle	$10,765	$28,176	$0	$2,244	$10,485
Elbert	$11,060	$9,355	$50,340	$20,589	$35,153
El Paso	$12,979	$34,888	$35,765	$22,008	$39,777
Fremont	$7,662	$46,848	$0	$11,937	$33,528
Garfield	$8,947	$48,960	$0	$4,962	$42,909
Gilpin	$11,438	$7,026	$0	$10,569	$19,666
Grand	$9,353	$12,868	$0	$3,667	$50,421
Gunnison	$8,440	$25,110	$0	$3,553	$49,917
Hinsdale	$5,675	$0	$0	$93	$0
Huerfano	$10,123	$32,016	$0	$2,503	$33,672
Jackson	$1,199	$10,085	$0	$101	$59,673
Jefferson	$11,421	$36,316	$35,934	$14,518	$42,021
Kiowa	$4,678	$2,777	$0	$0	$32,932
Kit Carson	$7,764	$41,310	$0	$692	$37,477
Lake	$5,761	$9,491	$0	$954	$36,597
La Plata	$10,221	$31,454	$0	$26,435	$33,955

B3c: FY 2013-14 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$7,758	$37,969	$21,841	$10,463	$36,830
Las Animas	$16,017	$31,603	$0	$2,758	$41,171
Lincoln	$8,832	$21,201	$0	$1,314	$40,866
Logan	$8,634	$41,822	$0	$7,940	$26,129
Mesa	$14,307	$65,717	$0	$8,902	$34,795
Mineral	$1,969	$5,729	$0	$0	$7,491
Moffat	$7,461	$48,785	$0	$6,287	$36,151
Montezuma	$11,412	$32,799	$0	$8,626	$35,537
Montrose	$7,894	$36,209	$36,159	$14,661	$33,938
Morgan	$8,328	$31,641	$9,917	$3,893	$36,393
Otero	$5,936	$46,168	$0	$11,088	$33,323
Ouray	$16,051	$2,546	$0	$10,122	$24,710
Park	$8,303	$55,300	$0	$21,371	$0
Phillips	$5,797	$13,108	$0	$21,344	$30,937
Pitkin	$31,218	$0	$0	$821	$3,950
Prowers	$3,818	$47,045	$0	$5,427	$40,262
Pueblo	$8,528	$53,898	$37,876	$15,341	$35,732
Rio Blanco	$6,644	$12,107	$0	$2,629	$40,457
Rio Grande	$6,245	$34,973	$0	$3,227	$33,468
Routt	$4,600	$40,688	$0	$4,542	$48,648
Saguache	$8,021	$36,190	$0	$2,401	$15,506
San Juan	$5,611	$0	$0	$202	$0
San Miguel	$15,425	$4,257	$0	$2,202	$23,266
Sedgwick	$7,022	$46,819	$0	$4,464	$33,006
Summit	$15,576	$33,768	$0	$3,898	$28,378
Teller	$11,318	$19,188	$0	$22,925	$38,044
Washington	$5,368	$36,581	$0	$8,993	$28,684
Weld	$11,841	$38,442	$43,682	$9,600	$34,802
Yuma	$8,194	$18,352	$0	$1,249	$32,587
STATEWIDE	**$9,182**	**$28,640**	**$31,014**	**$7,932**	**$33,643**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties. “NR” denotes county included in "Suppressed Counties" category.

B3d: HCBS Waiver Programs Administered by the Department of Health Care Policy and Financing (HCPF)								
Fiscal Year	**Elderly Blind and Disabled; and Consumer Directed Care for the Elderly***	**Children's Home and Community-Based Services**	**Persons with Brain Injury**	**Persons with Mental Illness**	**Persons Living with AIDS**	**Children with Autism**	**Pediatric Hospice**	**Total HCPF**
FY 2008-09	18,618	1,334	264	2,489	71	89	42	**22,756**
FY 2009-10	19,848	1,314	253	2,641	67	113	84	**24,163**
FY 2010-11	20,890	1,285	249	2,786	60	108	120	**25,118**
FY 2011-12	22,385	1,179	255	2,966	57	99	151	**26,901**
FY 2012-13	23,527	1,204	275	3,248	57	85	162	**28,324**
FY 2013-14	24,642	1,202	298	3,407	49	87	167	**29,479**
*The Consumer Directed Care for the Elderly waiver ended in December 2007, coinciding with the implementation of the Consumer Directed Attendant Support Services benefit in the Elderly, Blind and Disabled waiver. Unduplicated client counts represent the number of unique clients who received a service in each category only.								

B3e: HCBS Waiver Programs Administered by Department of Human Services (DHS)					
Fiscal Year	**Children's Habilitation Residential Program**	**Supported Living Services**	**Developmentally Disabled**	**Children's Extensive Support**	**Total DHS**
FY 2008-09	156	3,285	4,379	423	**8,053**
FY 2009-10	165	3,270	4,482	431	**8,223**
FY 2010-11	150	3,235	4,395	422	**8,114**
FY 2011-12	120	3,307	4,371	399	**8,136**
FY 2012-13	90	3,350	4,490	433	**8,204**
FY 2013-14	82	3,519	4,848	800	**8,856**
Unduplicated client counts represent the number of unique clients who received a service in each category only.					

B3f: Long-Term Care Programs Administered by Department of Health Care Policy and Financing					
Fiscal Year	**Home Health**	**Program for All-Inclusive Care for the Elderly**	**Class I Nursing Facilities**	**Class II Nursing Facilities**	**Total Nursing Facilities (Classes I and II)**
FY 2008-09	10,902	1,794	13,614	22	**13,636**
FY 2009-10	10,982	2,013	13,583	38	**13,621**
FY 2010-11	11,859	2,214	13,650	35	**13,685**
FY 2011-12	12,079	2,665	13,939	20	**13,959**
FY 2012-13	13,047	2,765	14,122	21	**14,143**
FY 2013-14	15,674	2,601	14,015	23	**14,038**
Source: Medicaid paid claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 2003-06) one and one-half months (FY 2006-07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.					

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B4a: FY 2013-14 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	3,544	$26,482,885	$7,473
Alamosa	171	$1,339,620	$7,834
Arapahoe	3,252	$24,951,151	$7,673
Archuleta	71	$491,866	$6,928
Baca	NR	NR	$6,535
Bent	NR	NR	$9,255
Boulder	977	$6,961,121	$7,125
Broomfield	153	$1,086,078	$7,099
Chaffee	66	$514,998	$7,803
Cheyenne	NR	NR	$5,675
Clear Creek	NR	NR	$7,554
Conejos	83	$636,671	$7,671
Costilla	NR	NR	$9,876
Crowley	NR	NR	$6,496
Custer	NR	NR	$6,339
Delta	162	$989,195	$6,106
Denver	4,459	$34,593,879	$7,758
Dolores	NR	NR	$6,193
Douglas	420	$2,928,621	$6,973
Eagle	264	$2,272,129	$8,607
Elbert	49	$366,998	$7,490
El Paso	3,267	$23,723,016	$7,261
Fremont	238	$1,840,411	$7,733
Garfield	422	$3,282,051	$7,777
Gilpin	NR	NR	$8,767
Grand	38	$326,655	$8,596
Gunnison	53	$337,202	$6,362
Hinsdale	NR	NR	$6,365
Huerfano	35	$324,164	$9,262
Jackson	NR	NR	$12,638
Jefferson	1,861	$14,195,118	$7,628
Kiowa	NR	NR	$6,845
Kit Carson	48	$391,114	$8,148
Lake	53	$407,741	$7,693
La Plata	253	$1,759,838	$6,956

B4a: FY 2013-14 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Larimer	1,318	$8,894,861	$6,749
Las Animas	74	$586,381	$7,924
Lincoln	NR	NR	$7,580
Logan	122	$1,048,111	$8,591
Mesa	969	$5,734,960	$5,918
Mineral	NR	NR	$3,744
Moffat	104	$865,568	$8,323
Montezuma	195	$1,720,468	$8,823
Montrose	306	$2,030,644	$6,636
Morgan	249	$1,925,601	$7,733
Otero	153	$1,250,377	$8,172
Ouray	NR	NR	$5,329
Park	35	$239,951	$6,856
Phillips	34	$241,227	$7,095
Pitkin	NR	NR	$7,199
Prowers	99	$879,487	$8,884
Pueblo	1,252	$10,432,902	$8,333
Rio Blanco	31	$172,514	$5,565
Rio Grande	103	$747,814	$7,260
Routt	76	$596,972	$7,855
Saguache	47	$307,931	$6,552
San Juan	NR	NR	$6,489
San Miguel	NR	NR	$7,173
Sedgwick	NR	NR	$10,087
Summit	112	$692,400	$6,182
Teller	78	$576,118	$7,386
Washington	NR	NR	$7,464
Weld	1,873	$13,784,072	$7,359
Yuma	70	$518,353	$7,405
Suppressed Counties	NR	$5,975	$1,992
STATEWIDE	**303**	**$2,259,730**	**$7,458**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. "NR" denotes county included in "Suppressed Counties" category.

B4b: FY 2013-14 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type			
Delivery Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,902	$56,116,088	$9,508
Vaginal	19,822	$138,008,476	$6,962
Unknown/No Delivery Information	1,818	$11,584,399	$6,372
Total	**27,542**	**$205,708,963**	**$7,469**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Deliveries not classified (unknown) were identified via antepartum/stand-alone claims. Delivery method could not be ascertained with this data.

B4c: FY 2013-14 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date			
Age Group	**Unique Deliveries**	**Total Payments**	**Average Payment**
<=14	NR	NR	$8,060
15-19	2,963	$22,118,839	$7,465
20	1,593	$11,468,535	$7,199
21-24	7,358	$54,777,197	$7,445
25-34	12,802	$95,502,152	$7,460
35+	2,798	$21,638,475	$7,734
Unknown	NR	NR	$2,578
Total	**27,542**	**$205,708,963**	**$7,469**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Age groups below selected so Medicaid data may be used in conjunction with the CDC's PRAMS survey data. Age 20 separate so total EPSDT children may be obtained. Age 20 may also be added to 21-24 age group to match PRAMS age groups. "NR" denotes data is suppressed.

B4d: FY 2013-14 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's Eligibility Type on Delivery Date			
Eligibility Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Disabled Individuals to 59	302	$3,667,401	$12,144
MAGI Parents/Caretakers	4,242	$34,181,657	$8,058
MAGI Adults	100	$594,005	$5,940
Eligible Children	522	$4,028,874	$7,718
Foster Care	118	$1,174,415	$9,953
Baby Care Adults	16,327	$126,876,689	$7,771
Baby Care Children	946	$7,167,806	$7,577
Non-Citizens	4,105	$21,301,220	$5,189
Legal Immigrant Prenatal	847	$6,537,574	$7,719
Other Medicaid Eligibility Types	33	$179,323	$5,434
Total Medicaid	**27,542**	**205,708,963**	**7,469**

B4e: FY 2013-14 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit (NICU) Claims by Severity of Condition and Needy Newborn Status						
Most Severe Classification*	**Unique Clients**	**Unique Clients: Not Needy Newborn**	**Unique Clients: Needy Newborn**	**Total LBW / Preterm / NICU Payments**	**Payments: Not Needy Newborn**	**Payments: Needy Newborn**
Low Birthweight Infants						
Extremely Low BW (<1000 grams)	240	73	167	12,588,884	1,943,630	10,645,254
Very Low BW (1000 - 1499 grams)	322	50	272	10,467,967	991,363	9,476,604
Low BW (1500-2499 grams)	3190	213	2977	14,928,063	664,087	14,263,975
All LBW Clients	**3,752**	**336**	**3,416**	**37,984,914**	**3,599,080**	**34,385,833**
Preterm Infants Not Classified as Low Birthweight						
Very Preterm (<32 weeks gestation)	311	55	256	4,301,251	293,802	4,007,449
Moderately Preterm (32 to 36 weeks gestation)	451	41	410	1,460,278	68,412	1,391,866
All Preterm Infants not identified via LBW	**762**	**96**	**666**	**5,761,529**	**362,214**	**5,399,315**
Infants Treated in the NICU Not Due to LBW or Preterm						
NICU - Other, Including Normal Birthweight	2633	232	2401	7,740,109	348,093	7,392,016
TOTAL	**7,147**	**664**	**6,483**	**51,486,551**	**4,309,388**	**47,177,164**

*Individuals assigned to classifications according to the most severe diagnosis code associated with his or her claims during the fiscal year. Source: Medicaid paid claims from MMIS-DSS. Notes: Data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent clients who received a service in each category only. Needy Newborns are infants born to mothers who had Medicaid eligibility at the time of the infant's birth. Needy Newborns are identified via Program Aid Code H2.

B4f1: FY 2013-14 Clients and Costs Associated with Neonatal Intensive Care Unit Claims (DRG)		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Neonates, Died or Transferred to Another	42	126,344
Full-Term Neonate with Major Problems	402	1,813,015
Neonate with Other Significant Problems	754	1,686,078
Neonates < 1,000 grams	36	2,538,629
Neonates 1,000-1,499 grams	79	2,196,508
Neonates 1500-1,999 grams	178	2,210,842
Neonates > 2,000 grams with RDS	114	1,444,779
Neonates > 2,000 grams, Premature with Major Problems	147	904,261
TOTAL NICU Payments	**1,752**	**12,920,456**

*Clients may have claims for more than one NICU DRG. Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. "NR" denotes data is suppressed.

B4f2: FY 2013-14 Clients and Costs Associated with Neonatal Intensive Care Unit Claims (APR)		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Extremely Low Birth Weight (All < 999G)	54	4,049,561
Neonate, Birth Weight 1000-1249g with Respiratory Distress Syndrome or Other Major Respiratory Condition or Major Anomaly	32	1,778,449
Neonate, Birth Weight 1250-1499G with Respiratory Distress Syndrome or Other Major Respiratory Condition or Major Anomaly	33	1,278,835
Other Very Low Birth Weight APR-DRGs	63	4,716,324
Neonate, BWT 1500-1999G with Respiratory Distress Syndrome or Other Major Respiratory Condition	44	818,721
Neonate, Birth Weight 1500-1999G with Operating Room Procedure or Other Significant Condition	136	1,501,172
Neonate, BWT 2000-2499G with Major Anomaly	36	670,648
Neonate, BWT 2000-2499G with Respiratory Distress Syndrome or Other Major Respiratory Condition	51	538,260
Neonate, Birth Weight 2000-2499G with Other Significant Condition	80	716,891
Neonate, BWT 2000-2499G, Normal Newborn Or Neonate with Other Problems	150	994,038
Other Low Birth Weight APR-DRGs	52	1,238,535
Neonate, Transferred <5 Days Old, Born Here	57	1,696,712

B4f2: FY 2013-14 Clients and Costs Associated with Neonatal Intensive Care Unit Claims (APR)		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Neonate, Birth Weight > 2499g with Major Cardiovascular Procedure	46	2,289,864
Neonate, Birth Weight > 2499g with Other Major Procedure	75	1,388,436
Neonate, Birth Weight > 2499g with Major Anomaly	165	1,868,627
Neonate, Birth Weight > 2499g with Respiratory Distress Syndrome or Other Major Respiratory Condition	214	1,240,816
Neonate, Birth Weight > 2499g with Congenital or Perinatal Infection	111	423,906
Neonate, Birth Weight > 2499g with other Significant Condition	813	1,396,935
Neonate, Birth Weight > 2499g, Normal Newborn or Neonate with Other Problems	1,256	1,714,541
NICU-Other APR-DRGs	42	540,164
TOTAL NICU Payments	**3,510**	**30,861,434**

*Clients may have claims for more than one NICU DRG. Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. "NR" denotes data is suppressed.

B4g: FY 2013-14 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY13-14)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Adams	1,015	6,408,993
Alamosa	36	183,262
Arapahoe	973	6,258,919
Archuleta	NR	60,278
Baca	NR	52,269
Bent	NR	<10,000
Boulder	234	2,042,665
Broomfield	57	339,326
Chaffee	NR	100,717
Clear Creek	NR	23,972
Conejos	NR	84,143
Costilla	NR	114,582
Crowley	NR	46,080
Custer	NR	12,735
Default (Presumptive Elig)	NR	<10,000
Delta	37	374,391
Denver	982	6,716,624
Dolores	NR	33,474
Douglas	104	646,954
Eagle	74	605,111
Elbert	NR	67,132
El Paso	889	7,385,439
Fremont	65	886,038
Garfield	130	888,826
Gilpin	NR	206,070
Grand	NR	168,928
Gunnison	NR	104,716
Huerfano	NR	246,734
Jackson	NR	<10,000
Jefferson	611	3,067,611
Kiowa	NR	<10,000

B4g: FY 2013-14 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY13-14)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Kit Carson	NR	18,097
Lake	NR	105,038
La Plata	59	469,851
Larimer	309	1,838,714
Las Animas	NR	64,153
Lincoln	NR	<10,000
Logan	NR	280,857
Mesa	286	2,349,644
Moffat	NR	302,548
Montezuma	45	463,727
Montrose	43	258,372
Morgan	42	289,397
Otero	NR	242,653
Ouray	NR	<10,000
Park	NR	<10,000
Phillips	NR	36,099
Pitkin	NR	14,233
Prowers	NR	77,524
Pueblo	295	2,991,715
Rio Blanco	NR	24,616
Rio Grande	NR	69,453
Routt	52	119,459
Saguache	NR	55,854
San Miguel	NR	45,828
Sedgwick	NR	42,424
Summit	NR	101,792
Teller	NR	213,903
Washington	NR	<10,000
Weld	413	3,812,951
Yuma	NR	34,127

B4g: FY 2013-14 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by County		
County Name	**Unique Clients (Assigned to County by Earliest Claim in FY13-14)**	**Payment (Assigned via Client County as of First Date of Service on Specific Claim)**
Total LBW / Preterm / NICU Clients & Payments	**7,147**	**51,486,551**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4h: FY 2013-14 Clients with and without a Neonatal Abstinence Syndrome Diagnosis Code			
Client Type	**Unique Clients**	**Total LBW/Preterm/NICU Claim Payments**	**Average Cost per Client**
Clients with a Neonatal Abstinence Syndrome Diagnosis (NAS) in FY13-14	201	$2016229	$10,031
Clients without an NAS Diagnosis in FY3-14	6946	$49470322	$7,122
Total	**7,147**	**$51,486,551**	**$7,204**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5a1: FY 2013-14 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures (DRG)					
Rank	**MDC**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	14	Pregnancy, Childbirth and the Puerperium	$44,141,317	12,353	$3,573.33
2	4	Respiratory System	$14,499,584	2,159	$6,715.88
3	5	Circulatory System	$14,101,175	1,049	$13,442.49
4	8	Musculoskeletal System and Connective Tissue	$13,897,300	1,329	$10,456.96
5	15	Conditions of Newborns	$13,444,058	2,259	$5,951.33
6	6	Digestive System	$13,262,270	1,784	$7,434.01
7	1	Nervous System	$10,224,422	1,199	$8,527.46
8		Pre-MDC Other	$10,017,278	131	$76,467.77
9	18	Infectious & Parasitic Diseases	$9,970,409	998	$9,990.39
10	11	Kidney and Urinary Tract	$7,684,973	725	$10,599.96
		Top Ten Totals	**$151,242,785**	**23,986**	**$6,305.46**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5a2: FY 2013-14 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures (APR)					
Rank	**MDC**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	14	Pregnancy, Childbirth and the Puerperium	$43,959,937	11,450	$3,839.30
2	8	Musculoskeletal System and Connective Tissue	$24,827,257	2,186	$11,357.39
3	15	Conditions of Newborns	$23,790,612	3,189	$7,460.21
4	4	Respiratory System	$23,537,039	4,100	$5,740.74
5	5	Circulatory System	$18,755,947	1,677	$11,184.23
6	6	Digestive System	$18,254,147	2,700	$6,760.80
7	18	Infectious & Parasitic Diseases	$15,243,143	1,548	$9,846.99
8	1	Nervous System	$14,871,723	1,760	$8,449.84
9		Pre-MDC Other	$14,199,746	592	$23,986.06
10	7	Hepatobiliary System & Pancreas	$10,503,301	1,445	$7,268.72
		Top Ten Totals	**$207,942,852**	**30,647**	**$6,785.10**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5b1: FY 2013-14 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures (DRG)					
Rank	**DRG**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	373	Vaginal Delivery without Complicating Diagnoses	$20,574,260	7,347	$2,800.36
2	370	Cesarean Section with Complicating Diagnoses	$7,344,115	1,009	$7,278.61
3	371	Cesarean Section without Complicating Diagnoses	$6,197,473	1,752	$3,537.37
4	372	Vaginal Delivery with Complicating Diagnoses	$5,635,197	1,491	$3,779.47
5	541	Extracorporeal Membrane Oxygenation or Tracheostomy	$5,242,430	62	$84,555.33
6	576	Septicemia without Mechanical Ventilator 96+ Hours, Age >17	$4,451,208	566	$7,864.33
7	317	Admit For Renal Dialysis	$2,789,560	46	$60,642.61
8	578	Infectious & Parasitic Disease with Operating Room Procedure	$2,591,790	113	$22,936.19
9	801	Neonates < 1,000 Grams	$2,538,629	36	$70,517.47
10	544	Major Joint Replacement or Reattachment of Lower Extremity	$2,441,551	217	$11,251.39
		Top Ten Totals	**$59,806,213**	**12,639**	**$4,731.88**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5b2: FY 2013-14 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures (APR)					
Rank	**DRG**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	560	Vaginal Delivery	$28,735,163	8,224	$3,494.06
2	540	Cesarean Delivery	$11,520,498	2,529	$4,555.36
3	720	Septicemia & Disseminated Infections	$9,054,112	1,050	$8,622.96
4	139	Other Pneumonia	$4,961,818	1,096	$4,527.21
5	304	Dors/Lumbar Fusion Excluding Curve Back	$4,666,956	224	$20,834.63
6	221	Major Small & Large Bowel Procedure	$4,113,300	302	$13,620.20
7	775	Alcohol Abuse & Dependence	$4,010,856	584	$6,867.90
8	710	Infectious and Parasitic Disease with Operating Room Procedure	$3,871,184	194	$19,954.56
9	138	Bronchiolitis & Respiratory Syncytial Virus & Pneumonia	$3,646,090	1,022	$3,567.60
10	004	Tracheostomy with Medical Ventilation for 96 + hrs	$3,623,370	40	$90,584.24
		Top Ten Totals	**$78,203,348**	**15,265**	**$5,123.05**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5c: FY 2013-14 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	789	Other Symptoms Involving Abdomen and Pelvis	$25,039,041	29,837	$839.19
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$16,384,573	26,824	$610.82
3	V58	Other and Unspecified Aftercare	$12,332,545	5,682	$2,170.46
4	780	General Symptoms	$11,459,747	23,005	$498.14
5	521	Diseases of Hard Tissues of Teeth	$10,486,987	7,136	$1,469.59
6	787	Symptoms Involving Digestive System	$7,560,450	18,722	$403.83
7	784	Symptoms Involving Head and Neck	$6,665,895	12,289	$542.43
8	724	Other and Unspecified Disorders of Back	$6,135,470	15,715	$390.42
9	V57	Care Involving Use of Rehabilitation Procedures	$5,468,513	16,492	$331.59
10	574	Cholelithiasis	$5,121,108	1,991	$2,572.13
		Top Ten Totals	**$106,654,330**	**157,693**	**$676.34**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5d: FY 2013-14 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	**Surgical Procedure Code**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	66.29	Other Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	$171,605	84	$2,042.92
2	66.32	Other Bilateral Ligation and Division of Fallopian Tubes	$66,144	36	$1,837.32
3	68.41	Laparoscopic Total Abdominal Hysterectomy	$51,873	8	$6,484.19
4	66.39	Other Bilateral Destruction or Occlusion of Fallopian Tubes	$28,391	17	$1,670.08
5	51.23	Laparoscopic Cholecystectomy	$25,592	13	$1,968.63
6	68.59	Other Vaginal Hysterectomy	$24,631	7	$3,518.72
7	68.51	Laparoscopically Assisted Vaginal Hysterectomy (LAVH)	$22,899	4	$5,724.81
8	47.01	Laparoscopic Appendectomy	$21,502	7	$3,071.71
9	83.63	Rotator Cuff Repair	$19,241	2	$9,620.58
10	81.45	Other Repair of The Cruciate Ligaments	$13,328	2	$6,663.95
		Top Ten Totals	**$445,207**	**180**	**$2,473.37**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5e: FY 2013-14 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V72	Special Investigations and Examinations	$19,158,330	61,908	$309.46
2	V20	Health Supervision of Infant or Child	$17,744,911	68,642	$258.51
3	V22	Normal Pregnancy	$7,258,593	8,469	$857.08
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,830,381	18,671	$205.15
5	250	Diabetes Mellitus	$3,171,363	9,086	$349.04
6	724	Other and Unspecified Disorders of Back	$2,791,834	9,858	$283.20
7	719	Other and Unspecified Disorder of Joint	$2,477,671	9,754	$254.02
8	V25	Encounter For Contraceptive Management	$2,347,593	7,915	$296.60
9	401	Essential Hypertension	$2,279,041	8,612	$264.64
10	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$2,214,269	14,150	$156.49
		Top Ten Totals	**$63,273,987**	**217,065**	**$291.50**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
*Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5f: FY 2013-14 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$1,375,328	6,587	$208.79
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$560,653	3,058	$183.34
3	724	Other and Unspecified Disorders of Back	$453,248	1,758	$257.82
4	V72	Special Investigations and Examinations	$453,205	1,389	$326.28
5	382	Suppurative and Unspecified Otitis Media	$424,851	2,074	$204.85
6	462	Acute Pharyngitis	$395,737	2,494	$158.68
7	780	General Symptoms	$376,635	2,197	$171.43
8	719	Other and Unspecified Disorder of Joint	$353,275	1,776	$198.92
9	789	Other Symptoms Involving Abdomen and Pelvis	$350,903	1,769	$198.36
10	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$350,599	2,151	$162.99
		Top Ten Totals	**$5,094,434**	**25,253**	**$201.74**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
*Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5g: FY 2013-14 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program Principal Diagnosis Categories, Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$18,064,532	134,203	$134.61
2	367	Disorders of Refraction and Accommodation	$13,688,597	79,975	$171.16
3	315	Specific Delays in Development	$11,460,169	7,579	$1,512.10
4	789	Other Symptoms Involving Abdomen and Pelvis	$10,995,479	62,606	$175.63
5	V25	Encounter For Contraceptive Management	$9,619,553	28,605	$336.29
6	650	Normal Delivery	$9,043,137	12,041	$751.03
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$8,636,457	86,131	$100.27
8	780	General Symptoms	$7,627,205	59,263	$128.70
9	784	Symptoms Involving Head and Neck	$6,219,683	37,184	$167.27
10	724	Other and Unspecified Disorders of Back	$5,828,733	33,752	$172.69
		Top Ten Totals	**$101,183,545**	**541,339**	**$186.91**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5h: FY 2013-14 Top 10 Dental Procedures Ranked by Expenditures					
Rank	**Procedure Code**	**Procedure Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	D8090	Comprehensive Ortho Adult Dentition	$15,149,181	4,962	$3,053.04
2	D2930	Prefab Stainless Steel Crown Primary	$7,695,112	25,088	$306.72
3	D1120	Prophylaxis Child	$7,000,418	173,356	$40.38
4	D7140	Extraction Erupted Tooth/Exposed Root	$5,343,303	37,843	$141.20
5	D2392	Resin Based Comp Two Surfaces Posterior	$5,235,353	35,015	$149.52
6	D7210	Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap	$5,235,280	20,838	$251.24
7	D0120	Periodic Oral Evaluation	$5,229,264	176,989	$29.55
8	D8080	Comprehensive Ortho Adolescent Dentition	$4,939,779	1,809	$2,730.67
9	D2391	Resin Based Comp One Surface Posterior	$4,410,066	38,247	$115.30
10	D0330	Panoramic image	$4,076,864	77,045	$52.92
		Top Ten Totals	**$64,314,619**	**591,192**	**$108.79**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5i: FY 2013-14 Top 10 Laboratory Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$3,486,304	59,729	$58.37
2	87591	Nisseria Gonorrhea, DNA, Amplified Probe Technique	$3,460,964	59,347	$58.32
3	80101	Drug Screen Single	$2,856,759	15,139	$188.70
4	80053	Comprehensive Metabolic Panel	$2,435,437	110,850	$21.97
5	85025	Complete Blood Count with Automated White Blood Cells Differential	$2,174,481	133,980	$16.23
6	81220	Cystic Fibrosis Transmembrane Conductance Regulator Gene Common Variants	$2,056,490	2,307	$891.41
7	84443	Thyroid Stimulus Hormone	$1,993,953	75,276	$26.49
8	81211	Breast Cancer Susceptibility 1&2 Sequence & Common Duplication Deletions Variants	$1,906,353	621	$3,069.81
9	80050	General Health Panel	$1,767,710	37,892	$46.65
10	80061	Lipid Panel	$1,527,264	78,425	$19.47
		Top Ten Totals	**$23,665,716**	**573,566**	**$41.26**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5j: FY 2013-14 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	E1390	Oxygen concentrator	$17,120,821	$16,934	$1,011.03
2	E0442	Stationary Oxygen, Liquid	$5,371,664	$4,499	$1,193.97
3	B4160	Enteral Formula for Pediatrics, Calorie Dense >/=0.7kc	$4,970,011	$1,622	$3,064.13
4	E0441	Stationary Oxygen, Gas	$2,876,530	$3,616	$795.50
5	B4161	Enteral formula for pediatrics, hydrolyzed/amino acids and peptide chain proteins	$2,816,389	$626	$4,499.02
6	T4527	Adult Sized Disposable Incontinence Product Large	$2,648,654	$3,519	$752.67
7	B4035	Enteral Feed Supplement, Pump, per day	$2,383,357	$1,303	$1,829.13
8	A4554	Disposable Underpads	$2,329,502	$8,423	$276.56
9	T4526	Adult Sized Disposable Incontinence Product Medium	$2,153,883	$3,699	$582.29
10	T4535	Disposable Liner/Shield/Pad	$2,016,933	$5,938	$339.67
		Top Ten Totals	**$44,687,745**	**50,179**	**$890.57**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5k: FY 2013-14 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	Abilify	Antipsychotics	$29,797,549	7,882	$3,780
2	Advair	Beta-Adrenergics and Glucocort	$8,718,211	9,850	$885
3	Proair	Beta-Adrenergic Agents	$8,662,111	73,072	$119
4	Norditropin	Anabolic Steroid	$8,114,717	418	$19,413
5	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$6,977,747	670	$10,415
6	Oxycodone	Analgesics	$6,901,163	70,572	$98
7	Humira	Anti-Inflammatory Tumor Necrosis	$6,609,098	486	$13,599
8	Methylphenidate	Anti-Narcolepsy/Anti-Hyperkin	$6,542,975	8,101	$808
9	Lyrica	Anti-Convulsants	$6,244,015	5,329	$1,172
10	Sovaldi	Nucleotide Analogue Inhibitor	$6,101,208	70	$87,160
		Top Ten Totals	**$94,668,794**	**176,450**	**$537**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within 45 day of the end of the fiscal year.

B5l: FY 2013-14 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	Oxycodone	Analgesic	224,752	$6,901,162	$31
2	Hydrocodon	Analgesic	202,357	$3,464,997	$17
3	Proair	Beta-adrenergic agents	140,949	$8,662,110	$61
4	Amoxicillin	Antibiotics	133,336	$1,649,243	$12
5	Lisinopril	ACE Inhibitor	101,430	$1,001,112	$10
6	Levothyroxine	Thyroid Hormone	88,643	$1,189,742	$13
7	Tramadol	Analgesics, Narcotics	87,897	$978,648	$11
8	Ibuprofen	NSAID	80,135	$915,023	$11
9	Azithromycin	Macrolides	77,160	$1,372,326	$18
10	Gabapentin	Anti-Convulsants	76,344	$1,725,081	$23
		Top Ten Totals	**1,213,003**	**$27,859,448**	**$23**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within 45 day of the end of the fiscal year.